Economic Value of Aboriginal Community Controlled Health Services

Dr Katrina Alford

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"There is no national strategy for community health and there is considerable variation in the services provided across jurisdictions" (ROGS 2013: 11.3)

"Every dollar that can be redirected into primary health care services, and particularly to ACCHS, from the public hospital system is money well spent" (Close the Gap Campaign Steering Committee 2013)

"An investment in Aboriginal and Torres Strait Islander health, including to the Community Controlled sector, not only works towards curbing health disparities, but is also an investment in Aboriginal and Torres Strait Islander employment" (Royal Australian College of General Practitioners 2014)

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Abbreviations

ABS Australian Bureau of Statistics

ACCHS Aboriginal Community Controlled Health Services

AHM Australian Health Ministers

AHMAC Australian Health Ministers' Advisory Council

AHW Aboriginal Health Worker

AIHW Australian Institute of Health and Welfare

AMS Aboriginal Medical Services

ARIA Accessibility/Remoteness Index of Australia (in Australian Standard Geographic Classification (ASGC) Remoteness Structure)

CAEPR Centre for Aboriginal Economic Policy Research (Australian National University)

CDEP Community Development Employment Projects program

COAG Council of Australian Governments

CtG Close the Gap (CtGSC Close the Gap Steering Committee)

DEEWR Department of Education, Employment and Workplace Relations (in late 2013 the Department of Education and the Department of Employment were created from DEEWR)

DoH/DoHA Department of Health formerly Department of Health and Ageing

FaHCSIA Department of Families, Housing, Community Services and Indigenous Affairs (in late 2013 this became the Department of Social Services (DSS). Indigenous Affairs and the Office for Women moved to Department of Prime Minister & Cabinet (PMC).

FTE Full-Time Equivalent (A standardised measure used in converting number of persons in part-time employment to full-time employment).

HWA Health Workforce Australia

IRHD Indigenous and Remote Health Division (formerly OATSIH)

MBS Medicare Benefits Schedule

NACCHO National Aboriginal Community Controlled Health Organisation

NATSIHP National Aboriginal and Torres Strait Islander Health Plan (2013–2023)

OATSIH Office for Aboriginal and Torres Strait Islander Health

OID CtG	Overcoming Indigenous Disadvantage Closing the Gap
OSR	Online Services Report (in AIHW Aboriginal and Torres Strait Islander Health Services Reports)
PBS	Pharmaceutical Benefits Scheme
PHC	Primary health care
ROGS	Report on Government Services
SCRGSP	Steering Committee for the Review of Government Service Provision
SEWB	Social and emotional wellbeing

Language

This Report refers to Aboriginal and Torres Strait Islander people. When the term Aboriginal is used it includes Torres Strait Islander people. The term Indigenous is used only when specifically used in cited reports.

FOREWORD

Acknowledgement to Country:

NACCHO wishes to acknowledge the traditional owners of the land of which we are meeting on the Ngunnawal people, Elders past and present.

National Aboriginal Community Controlled Health Organisation (NACCHO)

NACCHO is the national authority on Aboriginal Comprehensive Primary Health Care representing over 150 Aboriginal Community Controlled Health Services (ACCHS) across the country on Aboriginal health and wellbeing issues. It has a history stretching back to a meeting in Albury in 1974.

An Aboriginal Community Controlled Health Service is a primary health care service initiated and operated by the local Aboriginal community to delivery holistic, comprehensive and culturally appropriate health care to the community which controls it, through a locally elected Board of Management. The first Aboriginal Community Controlled Health Services was established in Redfern in 1971 because mainstream services were not dealing adequately with the health needs of Aboriginal and Torres Strait Islander people. This problem with mainstream health services continues to the present day.

Aboriginal Community Controlled Health Services operate in urban, regional and remote Australia. They range from large multi-functional services employing several medical practitioners providing a wide range of services, to small services which rely on Aboriginal Health Workers and/or nurses to provide the bulk of comprehensive primary care services, often with a preventive, health education focus. The services form a network, but each is autonomous and independent both of one another and of government. The ACCHS model of service is in keeping with the philosophy of Aboriginal community control and the holistic view of health. Addressing the ill-health of Aboriginal people can only be achieved by local Aboriginal people amounting to Aboriginal Health in Aboriginal Hands.

Definition of Aboriginal Health

Aboriginal health means "not just the physical well-being of an individual but refers to the social emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community.

It is a whole of life view and includes the cyclical concept of life-death-life.

Definition of Aboriginal Community Controlled Health Services

Defined as a Community Controlled process which allows the local Aboriginal community to be involved in its affairs in accordance with whatever protocols and procedures are determined by the Community.

The term Aboriginal Community Control has its genesis in Aboriginal peoples' right to self-determination.

An Aboriginal Community Controlled Health Service is:

- An incorporated Aboriginal Organisation;
- Initiated by a local Aboriginal Community;
- Based in a local Aboriginal Community;
- Governed by an Aboriginal body which is elected by the local Aboriginal community;
- Delivering a holistic and cultural appropriate health service to the Community which controls it.

Definition of Indigenous Primary Health Care Service

A mainstream organisation that is funded by the Australian government to provide Aboriginal health programs to Aboriginal and Torres Strait Islander people.

Close the Gap

Most Australians enjoy one of the highest life expectancies of any country in the world. This is not true for Aboriginal and Torres Strait Islander people.

Indigenous Australians can expect to live 10-17 years less than other Australians. Babies born to Aboriginal mothers die at more than twice the rate of other Australian babies, and Aboriginal and Torres Strait Islander people experience higher rates of preventable illnesses such as heart disease, kidney disease and diabetes.

The Close the Gap campaign has achieved a tremendous amount since its launch by Cathy Freeman and Ian Thorpe in 2007. These outcomes include:

- Commitment by government and all major political parties to take action through the formal signing of the Statement of Intent
- Allocation of additional health funding through COAG; and
- A stated intention to work in partnership with Indigenous health organisations and communities.

This is just the beginning. Change will take a generation. We need sustained action from Federal and State Governments.

Justin Mohamed – Chairperson of NACCHO

INSERT JUSTIN's Picture and get text to run along side of it.

Justin Mohamed is a Gooreng Gooreng man from Bundaberg in Queensland. He worked with Victorian Aboriginal communities for 20 years before being elected to his current role as Chairperson of the National Aboriginal Community Controlled Health Organisation (NACCHO). As NACCHO Chair, Justin is a strong advocate for the rights and self-determination of Aboriginal people and fights for the recognition of more than 150 Aboriginal Community Controlled Health Services as key to closing the appalling gap between Aboriginal and non-Aboriginal health outcomes.

Dr Katrina Alford - Author

Dr Katrina Alford (B.A. B.Ed. PhD University of Melbourne) is a health economist with an extensive record of reports and publications in Australian and international arenas. In the past 15 years she has worked as a health economist at the University of Melbourne Schools of Rural Health and Population Health, the Australian National University and Deakin University. Dr Alford works with a range of Aboriginal organisations at a regional and national level.

The Report acknowledges contributions from Professor Ian Ring and Adjunct Associate Professor John Goss. Professor Ring is a Professional Fellow in the Australian Health Services Research Institute at the University of Wollongong, with expertise in public health and Aboriginal and Torres Strait Islander Health. Adjunct Associate Professor John Goss of the Centre for Research and Action in Public Health at the University of Canberra was previously Principal Economist in the Expenditure and Economics Unit of the Australian Institute of Health and Welfare.

Key messages

The health funding system in Australia is unhealthy. There is a major need for reform of the funding system for Indigenous health in Australia if the Closing the Gap targets are to be achieved.

Despite increased health expenditure until recently, health gains over the past decade have been fewer than expected, reflecting the fact that ***the primary health care sector that delivers the best results for Aboriginal Australians is the least funded — Aboriginal Community Controlled Health Services (ACCHS).***

A major overhaul of funding systems is required to achieve better returns on the considerable amounts of money currently expended.

Unlike government funding for mainstream health services which has risen and continues to rise, Australian government funding for Indigenous health was substantially reduced in 2012-13 and is projected to fall further behind Aboriginal and Torres Strait Islander population growth and overall health expenditure in the three years from 2013-14. An estimated $263 million in the next three years will be cut from the Indigenous health budget.

Funding for ACCHS services is unrelated to population size or need, is not indexed for inflation or service demand and is not distributed equitably within and between the States and Territories.

Too much money is being spent on hospitals. Up to two-thirds of Aboriginal people rely on Indigenous-specific primary health care services yet three-quarters of all government Indigenous health expenditure is on mainstream services and nearly half of all expenditure is on hospitals.

High levels of avoidable hospital admissions and avoidable deaths primarily reflect inadequacies in the provision of primary health care.

Major mainstream programs such as MBS and PBS (Medicare Benefits Schedule, Pharmaceutical Benefits Scheme) ***fail to deliver*** for Aboriginal and Torres Strait Islander people ***with lower per capita use despite much higher levels of need.***

The failure of mainstream programs to deliver adequately lies at the heart of the continuing disadvantage of Aboriginal and Torres Strait Islander people.

ACCHS services outperform mainstream services in terms of access and outcomes. In part, this is because mainstream programs deliver clinical care rather than the comprehensive primary health care required to deal with both the cultural aspects of care and the particular needs of a small section of the population with complex health needs, chronic disease and much higher levels of comorbidity.

Yet ***there is a pervasive assumption that mainstream health services are appropriate*** for Aboriginal people living in cities and urban areas. ***Aboriginal people want and deserve culturally appropriate primary health care. Mainstream services do not deliver this and are at best a partial substitute for ACCHS.***

Denying this threatens the precarious health of Aboriginal people who defer or avoid timely, effective primary health care.

As a rough guide, Aboriginal and Torres Strait Islander people comprise 3% of the population and, on the most conservative basis, have a relative need of at least twice that of the rest of the population

because of much higher levels of illness, so ought to be receiving approximately 6% of funding for mainstream programs, a level rarely, if ever achieved. ***Funding ACCHS to address such system failures is a pressing priority.***

Transition to community control of primary health care services is consistent with broader government objectives regarding Aboriginal and Torres Strait Islander service and funding reforms, including improvements in access to services, coordinating services and partnerships between communities and government.

Funding ACCHS to address health system failures is a pressing priority for ***economic*** as well as health reasons. *Closing the Gap* reports and various health indicators obscure ***the positive economic value*** of the ACCHS network of 150 ACCHS and up to 300 outlying clinics and sites across Australia. They provide ***employment, economic independence and higher levels of education.***

Achievement of the *Closing the Gap* targets ***requires in the short and medium term, an increase in Indigenous health expenditure to redress recent cuts to expenditure in real terms, match increases in population demand and inflation and rectify current regional and jurisdictional service deficits. In the longer term the potential for direct cost savings as health outcomes improve is substantial,*** as well as additional budget savings in areas such as welfare and the justice system.

This should be part of a coherent and transparent formal process to provide greater equity in Aboriginal primary health care funding. **Culturally appropriate methods of health service delivery ensure equitable access.**

Investing in ACCHS provides a better return on investment than mainstream services. They are ***cost-effective,*** add ***substantial economic value to Aboriginal communities and generate flow-on effects to education and other sectors.***

Executive Summary

Background

The Australian Bureau of Statistics (ABS, 2012) estimated that as at June 2011, 669,881 people identified as Aboriginal and Torres Strait Islander, 3% of the total Australian population. Life expectancy for Aboriginal and Torres Strait Islander people is estimated to be ten years less than the national Australian average, with high levels of disadvantage in areas such as education, employment and housing all contributing to disproportionately low health outcomes.

Aboriginal Community Controlled Health Services have up to 45 years' experience in delivery of culturally appropriate Comprehensive Primary Health Care to Aboriginal and Torres Strait Islander people. They are the largest employer industry of Aboriginal and Torres Strait Islander people within Australia, estimated at 5829 workers, 3,215 who are Aboriginal and Torres Strait Islander. The ACCHS workforce provide 2.5 million episodes of care to

An estimated 342,000 Aboriginal & Torres Strait Islander people and other Australians annually. ACCHS have successfully contributed to the Close the Gap targets that have reduced child mortality rates by 66% and overall mortality rates of Aboriginal and Torres Strait Islander people by 33% over the last two decades.

Despite increased health expenditure over the last decade, up until recently health gains have been fewer than expected. The primary health care sector that has demonstrated an ability to deliver the best results for Aboriginal Australians– Aboriginal Community Controlled Health Services, continues to be the least funded. As the Commonwealth Government prepares to announce the findings of the National Commission of Audit conducted to assess the role an scope of government expenditure leading into the Federal Budget announcements in May 2014. This Report offers an alternative analysis of the gaps, barriers that are to be addressed if NACCHO, Affiliates and ACCHS are to continue to deliver positive gains in Closing the Gap on health outcomes for Aboriginal and Torres Strait Islander Australians.

INTRODUCTION

This Report is evidence-based and demonstrates the economic benefit and value that Aboriginal Community Controlled Health Services nationally provide to the Australian economy and society. NACCHO engaged an independent consultant Dr Katrina Alford to develop the report on NACCHO's behalf. This report is the first health economics detailed study of Aboriginal Community Controlled Health Services (ACCHS) and related resource and funding issues in Australia.

The Report has a dual focus:

- Assessment and evaluation of the *economic (as well as health) value* derived from the ACCHS sector, and any additional cross-sector benefits including in employment, economic independence and education.

- Assessment and evaluation of *government policy and expenditure* on ACCHS, and on Aboriginal and Torres Strait Islander health more generally.

Methodology

The Report uses a multi-methodology approach, based on:

- *Literature, reports and refereed journal articles*, including Online Services Reports (OSR) on Aboriginal primary health care services, reports and data on Australian (and some international) Indigenous health, expenditure, health funding reform, population, policy and government budget papers.

- *Jurisdictional and geographical area evidence* (ARIA).

- *Longitudinal evidence* if available and relevant.

- *Cross-sector evidence* relating to the social determinants of health, including education and employment.

- *Advice and input from relevant academic experts* in Aboriginal and Torres Strait Islander health, expenditure and policy, including Professor Ian Ring and Adjunct Associate Professor John Goss.

- *National Aboriginal Community Controlled Health Organisation (NACCHO) sources* including interviews with NACCHO senior management, submissions to government and the NACCHO 2013 *Ten Point Plan 2013-2030: investing in healthy futures for generational change*.

- *A conservative multiplier-based analysis* of the benefits of investing in ACCHS.

- *Case studies* of ACCHS in different geographical areas.

- *Fifteen years experience* working with Aboriginal community and organisation leaders.

- The Report makes recommendations relating to the evidence and findings.

Limitations

The Report is constrained by the lack of ACCHS-specific evidence in reports on Aboriginal primary health care services.

Findings

Section 1 Overview

1.1 Health gaps
Aboriginal and Torres Strait Islander Australians do not access health services to the level expected given their health status for two main reasons —***an inadequate supply of comprehensive Aboriginal primary health care services and an inequitable share of mainstream programs — lie at the heart of the problem***. Government funding distributions ignore demographic trends and health needs.

1.2 Government health policy
The Commonwealth has the main responsibility for primary health care for Aboriginal and Torres Strait Islander Australians. Transition to community control is a recognised policy objective but there is no national strategy for community health. An estimated 51% to 61% of Australia's Aboriginal population annually visit Aboriginal primary health care and ***Aboriginal Community Controlled Health services - ACCHS. The potential for a well-resourced Aboriginal primary health care sector to directly address determinants of the health gap is substantial.***

1.3 Health outcomes (Table 2)
Mainstream primary health care services are not working well for Aboriginal people. Continuing health system issues result in ***unmet health and wellbeing needs, accessing mainstream primary care and preventive health services less, later and less frequently, resulting in a higher burden of disease, avoidable mortality and poorer quality of life than for non-Aboriginal Australians.***

1.4 *'Four A'* barriers to access
More than half of all Aboriginal avoidable deaths relate to primary prevention. Availability, Affordability, (Cultural) Acceptability and Appropriateness (to health need) barriers persist in all States, Territories and geographical areas, and major cities in particular. Relatively few ACCHS services are funded for a full range of comprehensive primary health care activities.

1.5 Preference for Aboriginal-specific primary health care (PHC) services (Tables 9, 11, 13, 14)
A long-standing barrier that governments refuse to meaningfully address is Cultural Acceptability. Cultural competency issues pervade the mainstream health system with little evidence of improvement. Recognition of the problem has not resulted in its resolution. ***ACCHS are the dominant choice of Aboriginal people in all geographical areas, despite low levels of ACCHS availability in all geographical settings.*** In areas with more Aboriginal primary health care services on a population basis, proportionately more Aboriginal people use them. ***Current utilisation (and under-utilisation) patterns are the result of a chronic shortage of community-based and controlled Aboriginal Health Services***.

A pervasive assumption that mainstream health services are an acceptable substitute in urban Australia is not supported by evidence. Ignoring the strong preference for ACCHS jeopardises the precarious health of Aboriginal people resulting from deferred access to health services and under-utilisation of mainstream primary health services. The ***strong preference for 'own culture', 'own***

system,' 'own community control' primary health care services is indicated by 6.3% annual increase in demand for these services, notwithstanding supply and fiscal constraints on ACCHS.

1.6 Flawed administrative and resource allocation mechanisms (Tables 4.1, 4.2, 5, 7-10, 12)
Too much money is being spent on hospitals. High levels of avoidable admissions and avoidable deaths primarily reflect inadequacies in the provision of primary health care. Major mainstream programs fail to deliver with lower Aboriginal per capita use despite much higher levels of need. ***Yet government expenditure on Indigenous primary health care continues to be directed to mainstream rather than to Indigenous-specific organisations such as ACCHS. Funding for ACCHS is not based on health need, population growth, demand for services, inflation or jurisdictional equity.*** These indicators suggest poor health system performance against government performance framework measures of equity, effectiveness and efficiency.

1.7 Government funding issues (Tables 3-13)

Despite increased health expenditure until recently, health gains over the past decade have been fewer than expected, reflecting the fact that ***the primary health care sector that delivers the best results for Aboriginal Australians is the least funded — Aboriginal Community Controlled Health Services (ACCHS).***

Government funding lacks balance. Too much money is being spent on hospitals. Government funding issues include rationing Aboriginal health expenditure, under-utilisation of mainstream services, mainstreaming Indigenous expenditure, false economies resulting in avoidable and expensive hospital usage, sustainability and reporting issues, and failure to distribute funding equitably by a coherent, transparent, formal process.

Up to two-thirds of Aboriginal people rely on Indigenous-specific primary health care services. Yet three-quarters of all government Indigenous health expenditure is on mainstream services and nearly half (48.4%) of all expenditure is on hospitals (ROGS E 2012 Table 5.2). Maldistribution of funding adversely impacts on services and clients, in New South Wales, Tasmania and Queensland severely, and Victoria considerably.

As a rough guide, Aboriginal and Torres Strait Islander people comprise 3% of the population and, on the most conservative basis, have a relative need of at least twice that of the rest of the population because of much higher levels of illness, so ought to be receiving approximately 6% of funding for mainstream programs, a level rarely, if ever achieved.

Low levels of Indigenous primary health care funding allocations are highlighted by fact that in recent years, the relative share of ***Australian government funding directed towards (mainstream) primary health care has increased*** (AIHW 2014).

Unlike ***sustained growth in overall mainstream health expenditure that will continue to grow and reflect population growth***, ***Indigenous health expenditure is projected to decline, in real terms, relative to population growth and health needs.*** An ***additional $263 million*** should be expended between 2013-14 and 2016-17, just to retain the 2013-14 status quo in Commonwealth expenditure on Indigenous health. This is already low. ***Funding ACCHS to address such system failures is a pressing priority.***

Mainstreaming Aboriginal health expenditure and fiscal neglect of ACCHS may be increasing. If budget projections are implemented, ***ACCHS face a very lean future in fiscal terms, as they struggle to cater for a rapidly growing population with increasing demand for ACCHS services.***

Reforms are urgently needed to a health funding system that does not reflect population size or growth, health needs or service preferences, demand for services or equity between jurisdictions. This is jeopardising government aims to Close the Gap.

Achievement of the Closing the Gap targets requires:

- ***Strengthening rather than a diminution of funding for ACCHS.***
- ***Redirecting expenditure gap in relatively lower uptake of mainstream services by Aboriginal and Torres Strait Islander people to the ACCHS sector to better meet demand.***
- ***As a minimum, funding for ACCHS that is indexed for population growth, demand for services (needs index) and inflation.***
- ***A formal process to provide equity in the regional distribution of funding, within and between jurisdictions, taking into account population size, variable costs of service delivery, demand for services and limited substitution by mainstream services.***
- ***Regional analysis of health outcomes and service capacity to identify areas where new ACCHS are required.***

1.8 Economic costs of system failures

Poor health results in ***low labour force participation***, ***unemployment, productivity losses*** and ***high rates of welfare dependence. False economies***— limiting current primary health care funding — result in more expensive hospital-based services and allocative inefficiencies. Inequitable health outcomes are a drain on government budgets. ***In the short and medium term overall, Indigenous health expenditure needs to increase. In the longer term the potential for direct cost savings as health outcomes improve is substantial,*** as well as additional budget savings in areas such as welfare and the justice system.

ACCHS productivity is adversely affected by increasing consumer demand facing supply constraints. Flow-on effects of spending money on ACCHS rather than on expensive hospital-based services will reduce the negatives and increase the positives in the quality of life of Aboriginal Australians.

1.9 Transforming health outcomes with ACCHS (Tables 1, 14-18)

A hub and spoke model with 150 ACCHS across Australia and up to 300 individual clinics delivers holistic primary health care services. ACCHS are overwhelmed by demand, particularly in major cities.

1.10 Economic value of ACCHS (Table 18, Section 3)

A relatively large-scale employer of Aboriginal people and the main source of employment in many communities, ***ACCHS provide a channel for employment and economic growth in communities.*** ACCHS employment in predominantly skilled occupations increases the education and skill base of the Aboriginal workforce.

An expansion of the Aboriginal health sector could do more to ***promote regional development*** than an equal expansion of other sectors. It is a particularly cost-effective investment owing to the relatively small size of the Aboriginal population and labour market.

Depending on the size and distribution of expenditure, Aboriginal employment would increase and high unemployment rates eliminated, including among former CDEP (Community Development Employment Projects) workers.

Investing in ACCHS capacity building is a cost-effective multi-sector strategy that generates multiple benefits across sectors and communities. Strategies aimed at achieving improvements in any one area will not work in isolation. Investing in ACCHS is highly effective in meeting government policy goals and targets.

Section 2 Aboriginal Primary Health Care Services (PHC) and Aboriginal Community Controlled Health Services (ACCHS): the evidence

Section 2 indicates stark differences between the ACCHS and mainstream primary health care models.

2.1 Data limitations

ACCHS-specific data is not available in AIHW OSR and other government reports on Aboriginal primary health care services. ACCHS-specific data recently provided to NACCHO is summarised. This Report is the first ACCHS-specific health economics study in Australia. It draws on extensive health and health economics research literature. Further research would help to fully quantify the range of economic benefits of ACCHS.

2.2–2.3 Aboriginal PHCs and ACCHS (Tables 3-5, 7-10, 12-17)

ACCHS provide a broad range of preventive, population, cultural and community health and wellbeing services, in addition to individual clinical care activities and specialist referrals. ***ACCHS successfully address barriers to access and the overall social determinants of health.*** ACCHS productivity increases to date have been substantial, with large increases in episodes of care and client contacts compared with service growth. ***The complexity of Aboriginal health needs and range of clinical diagnostic and treatment procedures required would not be possible in many mainstream settings.***

Demand for ACCHS has increased by 6.3% annually, a much greater increase compared with alternative mainstream health service growth over the last few years. ***Increased reliance is being placed on ACCHS to support the primary health care needs of Aboriginal people, notwithstanding a trend towards mainstreaming Indigenous health expenditure and projected declines in per capita expenditure.***

Issues include supply constraints, variations in service distribution and rapid population growth. This may constrain further productivity growth and limit the supply of medical specialists and health professionals willing to work within ACCHS physical infrastructure and human resource constraints.

ACCHS staff are relatively highly educated and skilled, many with several tertiary qualifications. Organisational pathways require tertiary education and training and many ACCHS employ local trainees. ACCHS employment adds to the skill base of the Australian Aboriginal workforce.

2.4 ACCHS workforce issues

Supply constraints, under-representation and concentration in non-clinical, lesser paid sections of the health workforce, wage gaps, overall workforce shortages and policy options including partnerships and recommended workforce targets are discussed. ***The ACCHS workforce is highly skilled, but it is stressed by high demand and supply constraints.*** Funding insecurities including short-term and pilot programs are aggravating factors.

Increasing the Aboriginal health workforce is fundamental to achieving better health outcomes. ***The health workforce education/training sector is patchy, uncoordinated*** and is the subject of several sound recommendations in the (2013) *Review of Australian Government Health Workforce Programs*.

2.5 Evaluating ACCHS: government general performance indicators (Appendix 1)

Health services focused on body parts and clinical specialties are unlikely to be as effective as those offering a range of primary health care services in one place.

There is strong evidence that ACCHS deliver better health services to Aboriginal people, better quality services and more appropriately, efficiently and effectively than mainstream health services for Aboriginal people. ACCHS perform well in relation to the main principles of the general

performance framework used in *Reports on Government Services* — equity (access, outcomes), quality of services, appropriateness and effectiveness, and allocative and dynamic efficiencies.

Ineffective and inappropriate measures include governments perpetuating funding insecurity, lack of engagement with communities, racism, power inequalities and lack of community-embedded and controlled services that respond the most effectively to local needs and issues. ***A major influence on the poor health of Indigenous Australians is their marginal position*** in relation to mainstream society. International health studies indicate that ***creating conditions that enable people to take control of their lives improves health outcomes.***

Section 3 Case studies of Australian ACCHS

Three case studies illustrate ***the substantial economic and social value that ACCHS provide to local and regional communities,*** notwithstanding severe physical capacity constraints that hamper service delivery and limit medical specialist services in particular. ACCHS face ***perennial funding shortages and multiple short-term funding contracts. One large ACCHS has more than 90 funding agreements and compliance requirements, only 16% of which are recurrent grants.***

Clear ACCHS preference indicators include considerable distances travelled to access ACCHS, bypassing private GPs and mainstream health services on the way. ACCHS directly address cost and transport barriers, as well as the overall social determinants of health such as employment, poverty and education, either by directly providing broader health-related services, or by facilitating access to them. ACCHS are the principal source of Aboriginal employment in many communities.

Recommendations

If the Closing the Gap goals are to be achieved, NACCHO recommends that funding for ACCHS be placed on a much more rational and transparent basis as follows:

1 ***Funding security***

A broad spectrum of medical and health organisations strongly recommend that *closing the gap* programs and related services are quarantined from budget cuts across all federal, state and territory jurisdictions (RACGP 2014; CtGSC 2014, 2013; Russell 2013; RACP 2012).

2 ***Indexation of funding for ACCHS in line with standard government procedures***

As a minimum, funding for ACCHS should be indexed for inflation, population growth and service demand.

3 ***Inventory and identification of areas with inadequate levels of service provision***

An inventory of service gaps, needs and capacity building plan is needed. An area-based analysis of output and outcome indicators and service provision is required to identify areas where additional or enhanced ACCHS services are required.

4 ***Capital works program***

New services in areas of high demand, notably major cities, and inner regional areas to a lesser extent. For both maintenance and new infrastructure based on an inventory of current problems and future needs. The capital program should have an explicit aim of training and employing Aboriginal staff for the construction work.

5 ***Redress anomalies***

Funding for mainstream services continues to increase in line with population growth and size, but funding for ACCHS services for the section of the population with the greatest need has been cut and will be further reduced in real terms, despite outperforming mainstream services.

Adequate funding is required to redress reduced funding in 2012-13 from the previous year.

6 ***Address geographic inequities in funding***

A more transparent mechanism for deciding spending for ACCHS within and between jurisdictions is required - based on population size, need, remoteness and partial offsetting by mainstream services, with a phased scheme to increase funding for areas receiving less than their appropriate share.

7 ***Address system failure in mainstream programs***

New administrative mechanisms are required to address system failure in mainstream health programs:

i) The appropriate share of funding for each program that Aboriginal and Torres Strait Islander people should receive should be determined based on population size and level of need.

ii) New mechanisms introduced to address market failure by allocating funding to raise expenditure on Aboriginal and Torres Strait Islander people to the same level as any other section of the population of equivalent size and need.

iii) Allocate funding to whichever health service provides the best return on investment - with the default assumptions being

a) Aboriginal and Torres Strait Islander people comprise 3% of the population and have a needs index of at least 2, then as a rough guide 6% of mainstream health expenditure ought to be directed towards Aboriginal and Torres Strait Islander people.

b) ACCHS outperform mainstream services and would generally be the preferred provider.

c) Subcontracting funds to Medicare Locals through National Partnership Agreements should be redirected to ACCHS to maximise returns on investments in Indigenous health.

8 ***Preferred provider status***

ACCHS endorsement by government as the preferred provider of health services to Aboriginal and Torres Strait Islander communities (CtGSC 2014).

9 ***Key Performance Indicators for mainstream services***

Incorporate Key Performance Indicators for culturally competent health services into accreditation processes or funding/ reporting requirements (Royal Australasian College of Physicians 2012).

10 ***Aboriginal health workforce***

(i) Develop an Aboriginal Employment Strategy for the ACCHS sector.
(ii) Consideration of explicit Aboriginal employment targets for government programs that deliver goods, environmental or personal services (Mason 2013; Hunt 2013; Gray et. al. 2012).
(iii) Consideration of recommendations of *Review of Australian Government Health Workforce Programs* regarding Aboriginal health workforce resources (Mason 2013).

11 ***Data and information ACCHS***

Recommendations:

(i) A joint NACCHO/AIHW annual Report Card, containing quantitative data on population estimates by jurisdiction and geographical area, performance, service capacity in relation to need, expenditure, clients, episodes of care, client contacts, staff, workforce needs, education and training gaps and information needed to maintain good governance.
(ii) Provision of ACCHS-specific data in AIHW and ROGS *Reports on Government Services.*
(iii) Improvements to current ASGC-RA rural classification system (Mason 2013 recommendations 4.20, 6.7).

Section 1 Overview

1.1 Health gaps

Aboriginal and Torres Strait Islander Australians do not access health services to the level expected given their health status. Substantial barriers to accessing health services remain. Between a third and half of the health gap between Aboriginal and non-Aboriginal Australians is associated with differences in socioeconomic status such as education, employment and income. This indicates the importance of addressing social determinants as well as providing high quality health services (CtGSC 2014; Osborne et. al. 2013; Russell 2013; Marmot 2011; COAG 2012:B53) COAG 2012:B53).

Two factors — an inadequate supply of comprehensive Aboriginal primary health care services and an inequitable share of mainstream programs — lie at the heart of the problem.

The lack of Aboriginal Community Controlled Health Services (ACCHS) is a significant barrier to access to primary health care services (Sections 1.4, 1.5, Tables 8-10, 12). ACCHS are the preferred primary health care provider for many Aboriginal Australians. They are constrained by supply shortages, variations in service capacity and geographical and jurisdictional differences in ACCHS funding allocations that defy demographic trends and health needs.

Health gaps between Aboriginal and non-Aboriginal Australians: limited progress over 10 years

- Life expectancy at birth
  * 10 years gap between Aboriginal and Torres Strait Islander life expectancy and national Australian average. (Gap is 10.6 years for males and 9.5 years for females (ABS 2013))
  * Much lower life expectancy than Indigenous peoples in Canada (by 6.1 years), New Zealand (6.5 years), USA (4.1 years).

- Hope or despair?
  * Reduction in child mortality.
  * Some reduction in smoking and increases in child health checks.

  BUT
  * ↑ gap in self-assessed health status over past decade.
  * ↑ high/very high rates of psychological distress over past decade, ↑ gap.
  * Suicide rates more than twice the national average.

- Myth of ↓ health status and health resources by remoteness
  * Poor health status crosses geographical boundaries and jurisdictions.
  * Government health expenditure is heavily weighted towards remote/very remote areas. Analysis is needed to see if current funding allocations are justified by need and service delivery costs.

Sources: ROGS 2014, 2013 Table 12A.62; ABS Health 2013; Comparative evidence 2013; Australian Government Budget Papers 2013-14 Outcome 8: 159); AIHW HSR 2013; Scrimgeour & Scrimgeour 2008.

1.2 Government health policy

The National Aboriginal and Torres Strait Islander Health Plan 2013-2023 priorities include a "robust, strong, vibrant and effective community-controlled health sector", but not a commitment to appropriate funding. The Commonwealth has the main responsibility for primary health care for Aboriginal and Torres Strait Islander Australians, and a direct link to service delivery through its funding of Aboriginal Community Controlled Health Services and MBS and Pharmaceutical Benefits Scheme (PBS) payments.

However***, "(T)here is no national strategy for community health and there is considerable variation in the services provided across jurisdictions"*** (ROGS 2013: 11.3). The National Health Reform agreement by the Council of Australian Governments (COAG) in 2011 commits the Commonwealth, States and Territories to work together on system-wide policy and planning for primary health care and general practice services. Transition to community control is an important component of this joint work.

Government health funding is critically important to Aboriginal and Torres Strait Islander Australians. Government provides 95% of all Aboriginal and Torres Strait Islander health expenditure, compared with 68% for non-Aboriginal people (AIHW E 2013: 21). Aboriginal people rely on and need government financial support for a strong community health sector.

An estimated 51% to 61% of Australia's Aboriginal population visit Aboriginal primary health care services annually (Section 2.1, Table 13). The majority are clients of Aboriginal Community Controlled Health Services (ACCHS). The sector faces increasing pressure on staff and capacity due to increasing demand, supply shortages and funding constraints.

The lack of a coherent Indigenous primary health care policy or strategy and associated funding commitments results in inadequate and poorly distributed government expenditure on Aboriginal health, and in particular on Indigenous-specific, community based and controlled primary health care services. The predictable if expensive result is that **too much money is being spent on hospitals. High levels of avoidable admissions and avoidable deaths primarily reflect inadequacies in the provision of primary health care.**

A **"First-term agenda - Tackle Indigenous health"** for the Australian Government is strongly recommended by the health policy expert, Professor Stephen Duckett (2014). Integral to this is reform of the health financing system to give due weight to Aboriginal primary health care services.

The potential for a well-resourced Aboriginal primary health care sector to directly address determinants of the health gap is substantial.

1.3 Health outcomes

Table 1 indicates the Aboriginal and Torres Strait Islander population by geographical area. Table 2 presents selected health characteristics of the Aboriginal and Torres Strait Islander population in 2012-13 and comparisons with 2004-05 from National Health Surveys.

Table 1 Population: Aboriginal and Torres Strait Islander population 2001-11, by remoteness, Australia, 2011

Area	2011 no.	2011 %
Major Cities	233,146	34.8
Inner Regional	147,683	22.0
Outer Regional	146,129	21.8
Remote	51,275	7.7
Very Remote	91,648	13.7
Total Australia	**669,881**	**100.0**

Sources: ABS ATSI Remote 2013; census 2011 population estimates; ABS Demographic Statistics 2013; ABS 2009; census 2006, 2001.

Table 2 Health: Aboriginal and Torres Strait Islander Health Survey, by remoteness, Australia, 2004-05 — 2012-13 (%)

	Proportion of population (%)					
	2004-05			2012-13		
Selected health characteristics	**non-remote**	**remote**	**total**	**non-remote**	**remote**	**total**
Self-assessed health status: fair/poor	23.1(i)	18.6	21.9(i)	25.8 (i)	21.1	24.8 (i)
High/very high psych. Distress [(i)]	27.6 (i)	26.0	27.2 (i)	31.9 (i)	23.7	30.1 (i)
Number of long-term health conditions						
No current long-term health condition	32.5 (i)	43.4	35.4 (i)	29.4 (i)	44.8	32.7 (i)
Three or more	31.4(i)	22.4	29 (i)	35.3 (i)	23.2	32.7 (i)
Selected current long-term conditions [(iii)]						
Arthritis	10.4	5.6	9.1	10.4	6.4	9.5
Asthma	17.2 (i)	9.3	15.1 (i)	19.6 (i)	9.9	17.5 (i)
Back pain/problem, disc disorder	12.8 (i)	12.2 (i)	12.6 (i)	10.7 (i)	8.1 (i)	10.1 (i)
Diabetes/high sugar levels	na	na	na	7.3	11.2	8.2
Ear/hearing problems	11.8	13.4	12.2	12.5	11.6	12.3
Eye/sight problems	32 (i)	25.4 (i)	30.2 (i)	34.8 (i)	28.3 (i)	33.4 (i)
Heart and circulatory problems/diseases	11.0	14.1 (i)	11.8	10.7	16.9 (i)	12.0
Kidney disease(s)	1.4	3.0	1.8	1.6	2.1	1.7
Malignant neoplasm (cancer)	*1.0	0.3	0.8	1.0	0.5	0.9
Osteoporosis	1.1 (i)	0.4	0.9 (i)	1.7 (i)	0.9	1.5 (i)
Average all long-term conditions [(ii)]	9.9	8.4	9.5	11	9.6	10.7
Risk factor: overweight, obese	na	na	na	66.9	61.3	65.6

Source: ABS Health Survey 2013.
(i) The difference between 2004-05 and 2012-13 rates is statistically significant.
(ii) ABS population estimates for 2004-05 are not available hence a test of statistical significance is not possible for the average for all long-term conditions.
(iii) Persons who have a current medical condition which has lasted, or is expected to last, for 6 months or more.

Mainstream primary health care services are not working well for Aboriginal people (Russell 2013). *"The availability and uptake of early detection and early treatment services is... a significant determinant of people's health" (ROGS 2014).*

Continuing organisational, institutional and health system issues result in unmet health and wellbeing needs, accessing mainstream primary care and preventive health services less, later and less frequently compared with non-Aboriginal people, resulting in a higher burden of disease, avoidable mortality and poorer quality of life than for non-Aboriginal Australians.

While some clinical indicators have improved over the past decade, many others show little or no improvement. For the first time, the 2012-13 *National Aboriginal and Torres Strait Islander Health Survey* (Table 2) provides prevalence estimates of certain chronic diseases and conditions, Overall, chronic disease is on the rise with a 4% estimated annual increase over the past eight years in people with three or more long-term health conditions. Increases have been greater in non-remote (8% annual) than remote populations (1.5%; ABS Health 2013).

1.4 *' Four A'* barriers to access

"Access to the full range of primary health care professionals can be a major issue, either because the health professional required is not located in the region, or because an individual has physical, cultural or affordability barriers in getting to the health professional" (Australian Government 2009: 142).

Barriers to accessing mainstream primary health services contribute to the poorer health status of Aboriginal Australians and there is little evidence of improvement. Over the past twelve years the proportion of the Aboriginal population who visited GP/specialists and dentists in the past two weeks declined (by 0.3% annually; Table 11). A large-scale Australian study of mainstream GP visits indicates that less than 1% are Aboriginal or Torres Strait Islander clients, and 73% see no Aboriginal clients at all (University of Sydney 2013). Lack of effective and timely access to primary health care includes GPs "losing track of Aboriginal clients," difficulties following up treatments and ensuring compliance given irregular attendance (Taylor et. al. 2012).

Evidence of continuing barriers to access includes:

- **12% of Aboriginal Australians on average defer GP visits for more than a year because of costs, more than twice the rate of the total population (2012-2013 data, ROGS 2014).**
- **Gaps in access to early detection and early treatment services. Examples include lower proportions of older Aboriginal Australians having annual health assessments and Aboriginal women participating in breast screening, compared with their non-Aboriginal counterparts (ROGS 2013: 11.23).**
- **Diminished primary health care access illustrated by lower uptake of preventive interventions such as immunisation and screening programs results in increased presentations at tertiary centres at more advanced stages of potentially avoidable disease (Ong et. al. 2009).**
- **Disproportionately high "potentially avoidable GP-type presentations" to hospital casualty/outpatients, particularly in major cities and inner regional areas—1 in 6 -7 compared with less than 1 in 10 for other Australians (AHMAC 2012: 133; Russell 2013; Weightman 2013).**
- **Five times higher rates of potentially preventable hospitalisations across all jurisdictions and seven times higher hospitalisation rates for potentially preventable chronic conditions (AHMAC 2012).**
- **Potentially preventable hospital admissions (excluding those for dialysis) account for 26% of all hospital admissions. "Avoidable hospitalisations are an important indicator**

of effective and timely access to primary care, and provide a summary measure of health gains from primary care interventions" (Russell 2013).

- **Aboriginal deaths from all avoidable cases are 3.5 times the rate for other Australians. More than half (52%) of Aboriginal avoidable deaths relate to primary prevention (AHMAC 2012: 69).**

Nationally, the proportion of Indigenous primary healthcare services providing early detection services has varied little in the past three years. It appears that **relatively few (as low as 4%) ACCHS services are funded for a full range of comprehensive primary health care activities. Many are not, with considerable variations in the proportion of services providing early detection activities** (ROGS 2013: Tables 11A.24, 32; Martini et. al. 2011).

The substantial barriers to accessing mainstream primary health care services faced by Aboriginal and Torres Strait Islander Australians are described as the *Four A barriers*:

Availability (including access)

Affordability

(Cultural) Acceptability

Appropriateness (to health need)

18% of Australian GPs do not bulk-bill (ROGS 2014: 11.37). **ACCHS bulk-bill Aboriginal patients.** Their rates of deferred visits to GPs because of cost are relatively low in the Northern Territory (11%) and South Australia (7.7%), where there are proportionately more Aboriginal primary health care services (11%; ROGS 2014: Table 11A.35, 11A 36; see Table 8). **More than a third of Aboriginal Australians (35%) defer access to PBS medications for more than a year because of cost, more than four times the rate for the general population** (ROGS 2014: Table 11A.9; AIHW WF 2014).

1.5 Preference for Aboriginal-specific primary health care services (Tables 9, 11, 12, 13)

An Australian government priority "health enabler" in the National Aboriginal and Torres Strait Islander Health Plan 2013-2023 is "a culturally respectful and non-discriminatory health system" and a Commonwealth cross-sectoral implementation plan by 2014 (Australian Government NATSIHP 2013).

A long-standing key barrier that governments have persistently refused to meaningfully address is Cultural Acceptability. Cultural competency issues pervade the mainstream health system with little evidence of improvement. This is acknowledged in Australian Health Ministers Advisory Council reports (AHMAC). *"Indigenous people's reticence to use government services"* is noted by the Council of Australian Governments (COAG 2012: B53).

Recognition of the problem has not resulted in its resolution. **A pervasive assumption that mainstream health services are an acceptable substitute in urban Australia is not supported by evidence.**

ACCHS were established initially in urban areas to overcome the failure of mainstream services to address Aboriginal and Torres Strait Islander health needs. **ACCHS are the dominant choice of Aboriginal people in all geographical areas, despite low levels of ACCHS availability in all geographical areas** (Taylor et. al. 2012). The *Four A* barriers to primary health care also apply to urban Aborigines, particularly Acceptability and (cultural) Appropriateness of services (Scrimgeour & Scrimgeour 2008).

Aboriginal people's demand for ACCHS is growing rapidly and even faster than population growth. Where ACCHS exist, the community prefers to and does use them, suggesting patterns of use reflect patchy supply (Panaretto et. al. 2014). **Moreover, in geographical areas with relatively more Aboriginal primary health care services on a population basis, proportionately more Aboriginal people use them** (AIHW HSR 2013: 40). Case studies of three ACCHS in very different geographical areas of Australia (Section 3) indicate heavy demand from local communities as well as from further afield communities. Many Aboriginal people travel considerable distances to access their ACCHS, bypassing a number of mainstream GP services on route**. The proportion of the Aboriginal population accessing GPs/dentists and hospital casualty/outpatients services has not increased to the same extent as the demand for ACCHS services** (Tables 9, 11, 13).

Increasing "consumer preferences" for Aboriginal primary health care services is not a mere matter of individual choice or transitory consumer tastes. Placing a few more Aboriginal posters in waiting rooms and perhaps even cross-cultural training should not obscure **the risks to Aboriginal people's health from under-utilisation of mainstream health services and continued fiscal neglect of Aboriginal primary health care services.**

Indicators of this preference include:

- Mainstream system failure to tailor the system to the culture and community.
- Preferences for ACCHS over mainstream primary health care services and other documented barriers to accessing primary health care may aggravate an apparent supply/demand disequilibrium in the primary health care sector.
- An annual increase of 6.3% in demand for these services, notwithstanding supply and fiscal constraints on ACCHS (Table 13).
- Preference for ***'own culture', 'own system,' 'own community control'*** primary health care services (Taylor et. al. 2012; Scrimgeour & Scrimgeour 2008). [(1)]
- Evidence that ACCHS with salaried GPs are better able to address the complex health care needs of urban Aboriginal and Torres Strait Islander people. See Section 2.5.

Current utilisation (and under-utilisation) patterns are the result of a chronic shortage of community-based and controlled Aboriginal Health Services. Aboriginal people currently access different service providers, both Aboriginal-specific and private, as well as hospitals, community health and 24 hour GP services. Government reports illustrate little change or a relative decline in using alternatives to Aboriginal PHCs, and a strong and increasing preference for Aboriginal PHCs.

This is not highlighted or acknowledged in reports or in the distribution of health expenditure.

1.6 Flawed administrative and resource allocation mechanisms

"The complex, fragmented and often uncoordinated delivery systems that operate across primary health care have implications for the services individuals receive, how they pay for them, and how care providers interact and provide care...the primary health care sector...is less successful at dealing with the needs of people with more complex conditions or in enabling access to specific population groups that are hard to reach" (Australian Government PHC 2009:19).

[1] A large Aboriginal health survey (n=399) in South Australia for the South Australia Department of Health found that only 9% of Aboriginal respondents preferred a non-specific service and more than half preferred an Aboriginal-specific health service. Respondents who reported having not seen a service provider or used a health service at a time when they wanted to were statistically significantly more likely to live in metropolitan Adelaide and statistically significantly less likely to be in rural SA. ACCHS were the dominant choice in all geographical areas, despite high levels of no ACCHS availability of services in all 3 settings (Taylor et. al. 2012).

Administrative and resource allocation mechanisms regarding the Aboriginal population include:

• *Under-utilisation of mainstream health services* by Aboriginal and Torres Strait Islander people – exemplified by the continuing MBS gap (0.67: 1; AIHW E 2013).

• *Directing expenditure on Indigenous primary health care to Medicare Locals rather than to ACCHS.*

• *Too much money is being spent on hospitals*. High levels of avoidable admissions and avoidable deaths primarily reflect inadequacies in the provision of primary health care.

• *Funding not commensurate with need.* Substantial additional expenditure is required to achieve equitable access to effective health care for Aboriginal and Torres Strait Islander Australians (AHMAC 2012: 150, 165; RACP 2012).

• *Jurisdictional and geographical allocative inefficiencies.* Funding fails to account for variable populations and costs in different locations (Tables 7, 8, 10, 12).

• *Health system performance: equity, effectiveness and efficiency* are the three overarching performance indicators in annual *Reports on Government Services* (ROGS) measuring progress in health and other key sectors. Judged against these measures and their component parts including access, appropriateness and cost effectiveness, the health system's performance regarding Aboriginal Australians is poor. See Section 2.5, Appendix 1.

1.7 Government funding issues

Tables 3 - 12 present information relevant to government funding issues. This includes:

• All government health expenditure on Aboriginal and Torres Strait Islander people by main type of expenditure, 2004-05 to 2010-11 (Table 3).

• Australian government health expenditure for Aboriginal and Torres Strait Islander and total population, estimates and projections (Tables 4.1, 4.2).

• Mainstream and Indigenous-specific proportion of expenditure (Table 5).

• Proportion of expenditure by intensity of use and by cost (Table 6).

• All government Indigenous health expenditure, all government hospital service expenditure, ranking from highest to lowest per capita in each jurisdiction (Table 7).

• Aboriginal primary health care expenditure, services, clients and population in each State and Territory (Table 8).

• Aboriginal primary health care expenditure, services, clients, staff and population by geographical area (remoteness) (Tables 10, 12).

• Aboriginal and Torres Strait Islander population, primary health care services and episodes of care from 2001—2011-12 (Table 9).

• Aboriginal and Torres Strait Islander visits to GPs, specialists and hospital casualty/outpatients over the past twelve years (Table 11).

Table 3 All government health expenditure on Aboriginal and Torres Strait Islander population and ACCHS, per person, 2004-05—2010-11

Real expenditure per person ($) [(i)]	2004-05	2010-11	Av. annual growth 2004-05 to 2011-12 (%)
Australian government	**1,350.0**	**2,151.2**	**8%**
ACCHS grants [(ii)]	**527.3**	**752.8**	**6%**
MBS [(ii)]	222.1	492.9	14%
PBS	138.5	291.3	13%
Other Australian government	462.1	614.1	5%
State/Terr'y governments	**3,508.4**	**5,460.4**	**8%**
Admitted patient services in public hospitals	2,289.1	3,533.3	8%
Community health [(iii)]	**672.8**	**1,042**	**12%**
Other State/Terr'y	546.5	885.1	10%
Total governments	**4,858.40**	**7611.6**	**8%**

Source: AIHW expenditure data base; AIHW 2014: 24; 2008: 21.

Notes

The AIHW health expenditure report for 2011-12 was released while this Report was in press (AIHW 2014).

(i) Expenditure in constant prices is expressed in terms of 2010-11 prices.

(ii) Medical services provided through ACCHS are largely funded through MBS

(iii) State and Territory expenditure specifically on ACCHS is not available. Anecdotal reports suggest expenditure on ACCHS varies by jurisdiction and that not all community health expenditure is for ACCHS.

Table 4.1 Australian government health expenditure and forward estimates, 2011-12 —2016-17 ($ millions)

	Actual expenditure	Actual expenditure	Estimates	Projections		
	2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
	$m	$m	$m	$m	$m	$m
Medical & pharmaceutical services & benefits	33,253	35,996	36,691	39,094	41,005	43,110
Hospital services [(i)]	15,666	23,941	25,080	27,096	29,147	31,411
Other health services	7,114	6,362	7,053	7,418	7,481	7,413
General administration	3,057	3,192	3,337	3,273	3,296	3,327
Aboriginal and Torres Strait Islander health expenditure	**768**	**752**	**851**	**826**	**854**	**890**
Total health expenditure	59,858	62,249	64,636	68,081	71,597	75,493

Sources: Australian Government Budget Papers 2013-14: Statement 6 Table 8; 2012-13, 2010-11.

Notes

(i) Includes National Health Reform payments. A very small proportion is for public health (Budget Papers 2013-14: 3, 24).

Table 4.2 Australian government health expenditure and forward estimates, 2011-12 to 2016-17

		Actual expenditure	Actual expenditure	Estimates	Projections	Projections	Projections
		2011-12	2012-13	2013-14	2014-15	2015-16	2016-17
Total population	(no.)	22,723,000	23,130,900	23,544,943	23,966,394	24,395,392	24,832,070
Aboriginal and Torres Strait Islander population	(no.)	685,149	699,951	715,073	730,805	746,883	763,314
Aboriginal and Torres Strait Islander proportion of total expenditure	**(%)**	**1.28%**	**1.21%**	**1.32%**	**1.21%**	**1.19%**	**1.18%**
Aboriginal and Torres Strait Islander health expenditure per person	**($)**	**$1,121**	**$1,074**	**$1,190**	**$1,130**	**$1,143**	**$1,166**

Estimates and projections, annual change, 2011-12 to 2016-17

		2011-12 to 2016-17 Annual change %	2013-14 to 2014-15 Annual change %	2013-14 to 2016-17 Annual change %
Aboriginal and Torres Strait Islander health expenditure	(%)	↑ 3.2%	↓ 2.9%	↑ 1.5%
Total health expenditure	(%)	↑ 5.2%	↑ 3.8%	↑ 5.6%
Aboriginal and Torres Strait Islander population (%)		↑ 2.3%	↑ 2.2%	**↑ 2.2%**
Total population	(%)	↑ 1.9%	↑ 1.8%	↑ 1.8%
Aboriginal and Torres Strait Islander proportion of total expenditure	**(%)**	**↓ 0.02%**	**↓ 0.1%**	**↓ 0.05%**
Aboriginal and Torres Strait Islander health expenditure per person	**(%)**	**↑ 0.8%**	**↓ 5.0%**	**↓ 0.7%**

Sources: Australian Government Budget Papers 2013-14: Statement 6 Table 8; 2012-13, 2010-11; ABS Demographic Statistics 2013 Indigenous and total population growth rates; ABS 2009; census 2011, 2006.

Notes

E = Aboriginal and Torres Strait Islander population estimates are based on a 2.2% annual increase, and total population estimates 1.8% annual increase (ABS Demographic Statistics 2013).

Table 5 All government health expenditure: mainstream and Indigenous-specific, per person, Australia, 2010-11

	$	%
All government Indigenous health expenditure [(i)] ($)	$8,190	100%
Mainstream Indigenous [(ii)] ($)	$6,049	**74%**
Indigenous-specific ATSI [(ii)] ($)	$2,141	**26%**
All government non-Indigenous health expenditure	$4,054	

Source: ROGS 2012: 123, 150-3, Tables 5.1, 5.2.
Notes
(i) All government direct expenditure includes States/Territories. ROGS 2012 and AIHW 2013 expenditure estimates per person differ. See Table 3 and Section 2.1.
(ii) **Mainstream expenditure** is expenditure on services available to the total population on either a targeted or universal basis. **Indigenous-specific expenditure** is estimates based on services and payments explicitly targeted to Aboriginal Australians, either as complementary (additional) or substitutes (alternatives) for mainstream services.

Table 6 All government health expenditure: intensity of use and cost of service for Aboriginal and Torres Strait Islander people, by State and Territory, 2010-11

		Proportion of expenditure per person (%)								
		NSW	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**AUST**
Intensity of use [(i)]	**(%)**	87	75	93	84	78	92	83	91	88
Cost [(ii)] [(iii)]	**(%)**	13	25	7	16	22	8	17	9	12
Total government expenditure	**(%)**	100%	100%	100%	100%	100%	100%	100%	100%	100%

Source: ROGS 2012: 54, 155, Table 5.3.
Notes
(i) **Intensity of service use** component includes the use of mainstream services plus substitute Indigenous-specific services. Substitute Indigenous-specific services are programs, services and payments that are explicitly targeted to Indigenous Australians, and which are provided *as an alternative* to mainstream programs.
(ii) **Cost of service provision** component includes any additional cost of providing mainstream services to Indigenous Australians plus complementary Indigenous specific services. Complementary services are provided *in addition* to mainstream programs, services and payments.
(iii) Highest cost per person in order from highest to lowest is SA, Vic, ACT, NT, NSW, Qld, Tas.

Table 7 All government Indigenous health expenditure and hospital service expenditure, per person, ranking by State and Territory, 2010-11

	NT	ACT	WA	SA	Vic	Qld	NSW	Tas	AUST
All government expenditure: ranking highest to lowest (no.)	1	2	3	4	5	6	7	8	
All government expenditure ($)	$16,110	$9,863	$9,403	$9,104	$7,645	$7,278	$5,684	$3,822	**$8,190**
All government expenditure, comparison with total AUST - higher or lower (%)	**↑ 97%**	**↑ 20%**	**↑ 15%**	**↑ 11%**	**↓ 7%**	**↓ 13%**	**↓ 44%**	**↓ 114%**	**= 100**
Hospital service expenditure ($)	$5,302	$6,211	$4,937	$6,449	$3,327	$4,124	$2,709	$1,508	**$3,959**
Hospital service expenditure , ranking highest to lowest (no.)	3	2	4	1	6	5	7	8	**= 100**

Sources: ROGS E 2012: Table 5.2, Table 5.3.

Notes

All government expenditure is direct expenditure in all service areas and includes States and Territories.

Table 8 Aboriginal Primary Health Care (PHC) sector: distribution of services, clients, population, all government expenditure, by State and Territory, 2011-12

Proportion of all Aboriginal PHCs by State and Territory (%)

	NSW/ACT	Vic/Tas	Qld	WA	SA	NT	Aust
Services (%)	23.7	15.2	16.5	15.6	5.8	23.2	100
Clients [(ii)] (%)	25.1	7.9	24.9	20.3	4.6	17.2	100
Aboriginal and Torres Strait Islander pop'n (%)	**32**	**10.7**	**28.2**	**13.2**	**5.6**	**10.3**	100
Proportion of all government PHC expenditure for each State/Territory (%)	**21.4**	**7.8**	**25.4**	**15.5**	**6.0**	**23.9**	100

Sources: ROGS 2012: 152; AIHW HSR 2013: 40; ABS census 2011; Table 1.

Notes

(i) All government direct expenditure includes States & Territories; data is for 2011-11.

(ii) Annual client numbers understate the total client population. See Section 2.1 data limitations.

Table 9 Aboriginal Primary Health Care (PHC): services, episodes of care, population, Australia, 2001 — 2011-12

Year		Aboriginal and Torres Strait Islander population	Aboriginal PHCs Services	Aboriginal PHCs Episodes of care
		no.	no.	no.
2001	(no.)	410,003	159	1.2 million
2011-12	(no.)	669,881 (2011)	224	2.6 million
Annual ↑ (%)		**↑ 6.3%**	**↑ 4.9%**	**↑ 10.8%**

Sources: ABS census 2011, 2001; AIHW HSR 2013; AIHW no date; AHMAC 2012.

Table 10 Aboriginal Aboriginal Primary Health Care PHCs: distribution of services, clients, staff, ACCHS grants, population by remoteness, Australia, 2011-12

		Proportion of all Aboriginal PHCs by remoteness %					
		Major cities	**Inner regional**	**Outer regional**	**Remote**	**Very remote**	**Total**
Services	**(%)**	14.7	21.4	23.7	12.5	27.7	100.0%
Clients	**(%)**	21	17.8	20.5	21.8	18.9	100.0%
Staff	**(%)**	16	19	24	22	19	100.0%
Aboriginal and Torres Strait Islander pop'n	**(%)**	**34.8**	**22.0**	**21.8**	**7.7**	**13.7**	100.0%
OATSIH grants to ACCHS 2010-11	**(%)**	**20.7**	**20.4**	**23.7**		**35.2**	**100.0%**

Sources: AIHW HSR 2013: 97-8,119; AIHW ARIA 2013: 6; 2011 census.
Notes
Annual client numbers understate the total client population. See Section 2.1.

Table 11 Aboriginal and Torres Strait Islander service use: visits to GPs, dentists, hospital casualty/outpatients, Australia, 2000-01 — 2012-13

Year	Proportion of population (%) GP/specialists	Dentists	Hospital casualty/outpatients
	Visit last 2 weeks	**Visit last 2 weeks**	**Visit last 2 weeks**
	%	**%**	**%**
2000-01	21.8	5.9	7.7
2012-13	21.9	4.8	6.0
Annual	**↑ 0.01**	**↓ 0.1**	**↓ 0.1**

change (%)

Source: ABS Health 2013.

Table 12 Aboriginal Aboriginal Primary Health Care (PHC) services and GPs: ratio of services and GPs to population, by remoteness, Australia, 2011

	Aboriginal PHCs	Proportion of Aboriginal PHCs to Aboriginal and Torres Strait Islander pop'n	Proportion of GPs to total pop'n
Area	no.	Ratio	Ratio
Major cities	34	**1: 6,857**	**1: 861**
Inner regional	52	1: 2,840	1: 798
Outer regional	59	1: 2,477	1: 914
Remote	29	1: 1,768	1. 843
Very remote	61	1: 1,502	
Total AUST	**235**	**1: 2,851**	**1: 858**

Sources: AIHW HSR 2013: 97; AIHW Workforce 2013; 2011 census.

Notes

PHC service data is for 2010-11. Table 12 represents the proportion of Aboriginal primary health care services (PHCs) and GPs to the Aboriginal and Torres Strait Islander and total Australian population by geographical area in 2011.

This section of the Report provides evidence indicating that **reforms are urgently needed to a health funding system that does not reflect population size or growth, health needs or preferences, demand for services or equity between jurisdictions. It is short-changing a vulnerable population with specialised health needs and is jeopardising government aims to *Close the Gap.***

Achievement of the *Closing the Gap* targets requires:

- ***Strengthening rather than a diminution of funding for ACCHS. In the short and medium term, an increase in Indigenous health expenditure to redress recent cuts to expenditure in real terms*** (Tables 4.1, 4.2).
- ***Redirecting expenditure gap in relatively lower uptake of mainstream services by Aboriginal and Torres Strait Islander people to the ACCHS sector to better meet demand.***
- ***As a minimum, funding for ACCHS that is indexed for population growth, demand for services (needs index) and inflation*** (Tables 4.1, 4.2).
- ***A formal process to provide equity in the regional distribution of funding, within and between jurisdictions, taking into account population size, variable costs of service delivery, demand for services and limited substitution by mainstream services*** (Tables 4.1-12).
- ***Regional analysis of health outcomes and service capacity to identify areas where new ACCHS are required*** (Tables 7-10, 12).

1.7.1 Reducing Aboriginal health expenditure

As a rough guide, Aboriginal and Torres Strait Islander people comprise 3% of the population and, on the most conservative basis, have a relative need of at least twice that of the rest of the population because of much higher levels of illness, so ought to be receiving approximately 6% of funding for mainstream programs, a level rarely, if ever achieved (RACP - Royal Australasian College of Physicians 2012).

Low levels of Indigenous primary health care funding allocations are highlighted by fact that in recent years, the relative share of ***Australian government funding directed towards (mainstream) primary health care has increased*** (AIHW 2014). By contrast, Indigenous health expenditure overall, and Indigenous-specific funding for ACCHS in particular, is estimated to fall as a share of total health expenditure in the next three years (Table 4.2). ***Funding ACCHS to address such system failures is a pressing priority.***

Tables 3, 4.1 and 4.2 summarise trends in government health expenditure for Aboriginal and Torres Strait Islander people and the total population between 2004-05 and 2010-11 and forward estimates for 2013-14 to 2016-17.

All government real expenditure (taking account of inflation) per capita on Indigenous health increased by 8% annually between 2004-05 and 2010-11**. ACCHS-specific Australian government expenditure increased at a lower rate (6%) annually than expenditure on mainstream services including MBS (14%), PBS (13%) and public hospital admissions (8%) between 2004-05 and 2010-11** (Table 3). State and Territory government expenditure specifically on ACCHS is not available. Anecdotal reports suggest State and Territory expenditure on ACCHS varies by jurisdiction and that not all community health expenditure is for ACCHS. [2]

Australian government expenditure from 2011-12— 2012-13 and forward estimates to 2016-17 are presented in Tables 4.1 and 4.2. **Major reductions in Australian government Indigenous health expenditure occurred in 2012-13** (by 2.1%, compared with a 4% increase in overall expenditure). Two reasons were provided by government. Northern Territory Emergency Response expenditure ended in 2012, and **government wished to encourage Aboriginal people to use mainstream services** (Australian Government Budget Papers 2011-12: 6: 25; 2011-11 6).

The 2012-13 **Commonwealth budget expenditure forecasts from 2013-14 to 2016-17** indicate that all **government health expenditure for the total population will increase by 5.6% annually**, which is much higher than estimated annual population increases of 1.8% (Table 4.2). By contrast, projected 1.5% annual increases in Indigenous health expenditure fall well short of estimated annual population growth of 2.2%. This is a conservative population estimate. This means that **Indigenous health expenditure per capita will decline by 0.7% annually, and the proportion of all health expenditure allocated to Indigenous health fall by 0.05% annually in the next three years.**

To illustrate the magnitude of these proposed budget cuts, assuming that the proportion of government health expenditure allocated to Indigenous health remains stable over the three years from 2013-14, then an extra $70 million would be required in 2014-15, $89 million in 2015-16 and $104 million in 2016-17. **In all, an additional $263 million should be expended between 2013-14 and**

[2] All government expenditure on Indigenous-specific health services is 26% of all government Indigenous health expenditure (2010-11; ROGS E 2012: 123, 150-3). If ACCHS expenditure can be assumed to be an estimated 26% or $271 of State/Territory government community health expenditure per person, this would amount to estimated total government expenditure on ACCHS being about $1,024 per person or *about 13%* of all government Indigenous health expenditure in 2010-11. This estimate is conjectural. More detailed ACCHS-specific expenditure data is required.

2016-17, just to retain the 2013-14 status quo in Commonwealth expenditure on Indigenous health. This is already low.

Government expenditure projections for Indigenous health do not appear to be based on either population size and growth, or health need. They are, according to the former Australian Government, "due to the effect of movements of funds and a reduction in payments through National Partnerships over the forward estimates". **Unlike "sustained spending growth" in mainstream health expenditure that has grown and will continue to grow and reflect population growth, the proportion allocated to Indigenous health expenditure will shrink, in real terms, irrespective of population size or health needs** (Australian Government Budget Papers 2013-14, 2011-12; 2010-11; see Tables 4.1, 4.2).

Proposed budget cuts to Indigenous health pose a real danger that the health gains of recent years will be reversed. ACCHS suffered a big budget cut in 2012-13, with forward budget estimates foreshadowing a **very lean future in fiscal terms**, as they struggle to cater for a rapidly growing population with an increasing demand for ACCHS services. See Tables 4.1, 4.2, 13, Sections 2.2, 2.3.

The ACCHS case studies conducted for this Report (Section 3) indicate funding and resource issues, including funding insecurity, short-term and perennial pilot project funding, and endless and onerous reporting requirements. Not continuing to fund programs that have demonstrated success can contribute towards Indigenous people feeling loss, disappointment and anger at being let down by the system (Osborne et. al. 2013).

1.7.2 Under-utilisation of mainstream services

Sections 1.4 and 1.5 summarises indicators of barriers to accessing mainstream primary health care services and preference for Aboriginal-specific primary health care services.

Major mainstream programs such as MBS/PBS (Medicare Benefits Schedule, Pharmaceutical Benefits Scheme) **fail to deliver** for Aboriginal and Torres Strait Islander people **with lower per capita use despite much higher levels of need.** Australian government expenditure on all MBS/PBS services of $758.80 for each Aboriginal and Torres Strait Islander person and $1,031.20 for each non-Indigenous person represents a gap of $272.4 or ratio of 0.74:1 Indigenous to non-Indigenous expenditure per person. **As Aboriginal and Torres Strait Islander people receive a lower per capita benefit from mainstream services, this deficit in primary health services should be redressed through other programs such as the ACCHS.**

1.7.3 Mainstreaming government health expenditure

Notwithstanding evidence that Aboriginal people under-utilise mainstream health services and many prefer Indigenous-specific services, mainstream government expenditure dominates overall health expenditure for Aboriginal people. Up to two-thirds of Aboriginal people rely on Aboriginal PHC services. Yet three-quarters (74%) of all government Indigenous health expenditure is on mainstream services and 26% on Indigenous-specific services (Table 5). **Nearly one-half of all Indigenous health expenditure is allocated to hospitals.** Expenditure by all levels of government for ACCHS accounts for a relatively small proportion of this expenditure (Table 3; footnote 2; **Recommendations**).

Allocating proportionately less to Indigenous-specific health services and more to mainstream services appears to have escalated in 2011-12. The Australian Government reduced Indigenous health expenditure for 2012-13, partly because ***"Aboriginal and Torres Strait Islander people are able, and encouraged, to access mainstream services as well as Indigenous-specific services"*** (Australian Government Budget Papers 2011-12: 6: 25; 2011-11 6). Forward estimates in the 2012-13 budget (discussed in Section 1.7.1 and Tables 4.1, 4.2) indicate per capita expenditure reductions in

Australian government funding of Indigenous health from 2011-12 to 2016-17, and particularly from 2013-14 to 2016-17, which may suggest increasing mainstreaming of Indigenous health services and associated expenditure.

Australian government real expenditure on GPs has increased more than expenditure on Aboriginal Medical Services (AMS) in the past four years. In 2012-13, AMS expenditure was reduced by $6.7 million and expenditure on GPs increased substantially (ROGS 2014 Tables 11A.3, 11A.8). This may account for the 4.2% reduction in Aboriginal primary health care staff in 2012-13 (ROGS 2014 Tables 11A.8, 11A.18).

It is evident that mainstreaming Aboriginal health expenditure and fiscal neglect of ACCHS is increasing, with associated fiscal neglect of highly successful ACCHS programs.

A 'mainstream substitution assumption' appears to be pervasive in government circles, despite evidence of under-utilisation of mainstream primary health services, the *4A barriers* to access (Section 1.4) and preference for Indigenous-specific services (Section 1.5).

1.7.4 False economies: avoidable and expensive hospital service usage

"A dollar saved today may result in the need to spend many more in years to come. Every dollar that can be redirected into primary health care services, and particularly to ACCHS, from the public hospital system is money well spent" (CtGSC 2013).

Up to two-thirds of Aboriginal people rely on Indigenous-specific primary health care services. Yet three-quarters of all government Indigenous health expenditure is on mainstream services and nearly half (48.4%) of all expenditure is on hospitals (ROGS E 2012 Table 5.2). High levels of avoidable hospital admissions and avoidable deaths primarily reflect inadequacies in the provision of primary health care.

Short-term budget constraints on Aboriginal primary health care expenditure are **a false economy.** More primary health care spending now is cost-effective. It reduces the need for higher expenditure on more expensive hospital services.

- Aboriginal hospital expenditure: $3,959 per person ($2,277 million)
- Aboriginal public & community health expenditure: $3,152 per person ($1,813 million)

(ROGS E 2012: Tables 5.1, 5.2).

Under-utilisation of mainstream primary health care services and funding constraints limiting the growth of ACCHS underlie high rates of government expenditure on hospital services for Aboriginal people. In a health equity scenario in which Aboriginal people's hospital expenditure was the same as that for non-Aboriginal people, substantial cost savings could be redirected to increased investment on Aboriginal primary health care services, focussing particularly on avoidable hospital admissions.

1.7.5 Sustainability and reporting requirements

Compared with other parts of the health sector, ACCHS lacks a durable, sustainable funding base. As few as 4% receive grant funding in excess of $1 million for full comprehensive primary health care services. **Over 60% of grants are for one year or less ($1 million in 2009 dollars; Martini et. al. 2011). ACCHS have multiple, fragmented funding sources and complex contractual requirements involving a high workload to account and report to funders**. More effective funding and accountability arrangements should include long-term alliance contracts to enhance partnerships and capacity, better performance indicators and greater clarity in the relative roles of

national and jurisdictional governments (Lowitja Institute 2012; Martini et. al. 2011; Dwyer et. al. 2011).

1.7.6 Distribution of primary health care funding

1.7.6 (i) Rationale

Government expenditure and available budget reports do not include information on a standard core cost of delivering comprehensive primary health care, or a coherent, uniform weighting of allocations based on identified transparent criteria such as differential health needs, geographical classifications, cost variations, etc. (KPMG 2012). Hence it is impossible to establish the rationale or justification for different allocations to different sub-sectors, jurisdictions or geographical areas.

The higher health expenditure on Aboriginal and Torres Strait Islander people in remote and very remote areas is said to be "mainly due to higher expenditure on admitted patient services and the higher cost of delivering health goods and services" (AIHW ARIA 2013: vi, 1). Hospital admission rates partly explains the drivers of overall Aboriginal health expenditure (Table 7). However, **hospital service and cost variations do not appear to fully account for the sheer magnitude of differences in Aboriginal PHC and ACCHS funding by jurisdiction and remoteness** (Tables 7, 8, 10, 12). [(3)]

Resource allocations to Aboriginal primary health care services, and to ACCHS in particular, do not appear to be based on epidemiological, jurisdictional, geographical or demographic differences in health needs. This adversely impacts on the eastern States and major cities in particular. Health equity objectives may be better met by using a consistent, transparent and explicit process of health resource allocation (Ong et. al. 2009).

1.7.6 (ii) Specialised needs

As noted above (Section 1.7.1), health expenditure levels are not commensurate with the substantially greater and more complex health needs of Aboriginal and Torres Strait Islander people. The Royal Australasian College of Physicians suggests indexing Aboriginal expenditure by population size (3% or an index of three), multiplied by, at a minimum, an index of two to reflect greater health needs (RACP 2012). The Australian Health Ministers Advisory Council notes that while health expenditure on Aboriginal and Torres Strait Islander people (in 2009-09) was 39% higher than for other Australians, they experience rates 200% higher on a range of health measures such as mortality rates and prevalence of disease (AHMAC 2012: 165-6).

The Report is familiar with health research indicating that the magnitude of health needs is not necessarily equal to the magnitude of resources needed to rectify differential health needs (Ong et. al. 2009). However, **in the case of Aboriginal health needs and requisite resources required to redress substantial health gaps, it is clear that more adequate resources (and better distribution of these) is a prerequisite for improving health outcomes.**

1.7.6 (iii) Jurisdictional funding distortions

The distribution of services, clients, population, all government expenditure on Indigenous health and on Aboriginal PHCs by State and Territory (Tables 7 and 8) indicates the following:

[3] Table 6 provides details of cost variations between States and Territories, and indicates relatively higher costs in non-remote Victoria and the ACT than in largely remote Northern Territory. About a third of all admitted public hospital expenditure on Aboriginal peoples is in remote/very remote areas (ROGS 2012: Tables W-Y).

• Extreme jurisdictional differences in expenditure. These are more substantial than might be expected on the basis of variations in health needs, hospital service expenditure and costs (Tables 7, 8). [3]

• There are some links but also variations between hospital service and total expenditure eg. South Australia, Northern Territory (Table 7).

• All government Indigenous health expenditure per person is **4.2 times higher in the Northern Territory and Western Australia 2.5 times higher than in the least funded State, Tasmania, (Table 7).**

• Factoring in the costs of providing services does not appear to explain these differences — on average, 12% of per capita service expenditure is for the costs of service provision and 92% for intensity of use, with cost differences being a higher proportion of service costs in non-remote Victoria (25%), for example, than the Northern Territory (9%; see Table 6).

• Overall, Australian Indigenous health expenditure is about $8,190 a person (Table 7). **The dollar difference between the State and Territory with the most per capita expenditure is substantial — $12,288.** Ranking each State and Territory's per capita expenditure from the highest to the lowest, the Northern Territory ($16,110), the ACT ($9,863), Western Australia $9,403) and South Australia $9,104) are all above the Australian average. Falling well below it are Victoria ($7,645), Queensland ($7,278) and New South Wales ($5,684), with Tasmania ($3,822) at the bottom of the ladder.

• The distribution of services follows a somewhat similar pattern (Table 8). Northern Territory is the most serviced, having 23% of all services for 10% of the population. On a population basis, New South Wales, the ACT, Victoria, Tasmania and Queensland have the fewest services, with 71% of the population and 55% of all services. **New South Wales, Queensland, Victoria and Tasmania are the most severely strained by limited funding relative to client needs and population.**

• In sum, **one-quarter of all government expenditure on Aboriginal PHCs is for 10% of the population (Northern Territory). Nearly three-quarters of the population (Queensland, New South Wales/ ACT, Victoria and Tasmania) receives just over one-half of all expenditure.**

1.7.6 (iv) Geographical funding distortions

The 2012-13 national Aboriginal health survey (Table 2) indicates a relatively high burden of disease/distress for the overall population. However, while the remote-area population rates on some selected health indicators are poorer, the non-remote Aboriginal population has a proportionately higher incidence of long-term health conditions, higher rates of psychological distress, lower self-assessed health status and higher risk factors for poor health, and increasingly since 2004-05.

Self-assessments of health status are valuable but provide only a limited guide to clinical differences in health status and needs. Many reports indicate the substantially greater health needs of Aboriginal people in remote communities, particularly in the Northern Territory. However, **it would be difficult to fully justify substantial geographical differences in health expenditure (**Table 10) **on clinical or epidemiological grounds.**

A summary of Aboriginal Primary Health Care services, clients, staff, expenditure and population by remoteness in 2011-12 (Table 10) indicates:

• *Remote/very remote areas:* 21% of Australia's Aboriginal population has 40% of all services and receive over a third (35%) of all OATSIH grants.

• *Inner and outer regional areas*: inner regional areas receive less funding than expected on a population basis. Outer regional service and funding shares are approximately proportional to the population.
• *Major cities:* 35% of the population receives 21% of OATSIH grants and 15% of Aboriginal primary health care services.

The view or assumption that mainstream health services are an acceptable substitute in urban areas is not supported by evidence (see Sections 1.4 and 1.5).

The relative proportions of Aboriginal primary health care services (PHCs) and GPs to the Aboriginal and overall Australian population by geographical area (Table 12) are very different. Overall, for every 2,851 Aboriginal people there is an ACCHS. The GP to population ratio is one for every 858 people. The situation is particularly difficult for Aboriginal people in major cities, and regional areas to some extent. In major cities, there is one service for every 6,857 people.

The prevailing view is that mainstream primary health care services are a substitute for Indigenous-specific services in urban areas but available evidence does not support this view (see Sections 1.4, 1.5). Urban ACCHS supply shortages are aggravated by barriers to accessing mainstream primary health care services, notably quality issues, (cost) availability, acceptability and appropriateness. Many urban Aboriginal people do not rely on substitute mainstream GPs. They do not see any health provider at all, with reported adverse health consequences (Taylor et. al. 2012; Scrimgeour & Scrimgeour 2008).

AIHW OSR and other government Indigenous health reports including the annual Prime Minister's CtG report and reports by OID CtG, AIHW, AHMAC and ROGS do not highlight jurisdictional and geographical inequities in the supply of Aboriginal PHCs. There is **a particularly severe shortage of culturally appropriate PHC services for Aboriginal people, particularly those living in major cities** (Tables 8, 12).

1.8 Economic costs of system failures

• *Poor health* leads to low labour force participation and employment rates, productivity losses and high rates of welfare dependence.

• *False economies.* Delayed and/or reduced access to primary health services results in increased reliance on hospital-based services.

• *Low levels of capital and recurrent investment in ACCHS* have the potential to *constrain productivity growth*, with overstrained infrastructure, limited workforce capacity building and a limited supply of medical specialists working within ACCHS infrastructure.

• *Low returns from mainstream Aboriginal primary health care investments*. Overall funding increases to Aboriginal health in the past few years have not been reflected in big health outcome gains, owing to flawed administration and funding mechanisms that reinforce and perpetuate a system that is not working well for Aboriginal people. See Sections 1.6, 1.7 and 2.5.

• *Allocative inefficiencies in the health sector:* specifically in the supply of Aboriginal-specific primary health care services in relation to existing, unmet and potential demand.

• *Budget savings:* inequitable health outcomes are a drain on government budgets. Cost savings of about $2,770 million a year would result from equitable health outcomes between Aboriginal and

non-Aboriginal Australians. In the short and medium term, Indigenous health expenditure needs to increase to redress recent cuts to expenditure in real terms, match increases in population demand and inflation and rectify current regional and jurisdictional service deficits. The budget benefits are longer term.

1.9 Transforming health outcomes with ACCHS

There are 150 ACCHS across Australia, with up to 300 individual clinics operating in a hub and spoke model that caters for geographically dispersed Aboriginal and Torres Strait Islander communities (see Section 2.1 on data limitations). Operated by local Aboriginal communities, ACCHS are autonomous, community-controlled by a locally elected Board and supported by their peak council — the National Aboriginal Community Controlled Health Organisation NACCHO and its regional affiliates.

ACCHS provide holistic, comprehensive and culturally appropriate primary health care. They deliver health and broader social outcomes that are a challenge to mainstream services. ACCHS should be regarded as an exemplary, unique and culturally informed model of primary health care according to medical experts (Russell 2013; Weightman 2013; AHMAC 2012). See Section 2.5.

1.10 Economic value of ACCHS

"An investment in Aboriginal and Torres Strait Islander health, including to the Community Controlled sector, not only works towards curbing health disparities, but is also an investment in Aboriginal and Torres Strait Islander employment" (Royal Australian College of General Practitioners 2014).

"Health services, including ACCHSs...provide pathways to employment for community members through internships and 'in-house' training. This reduces welfare dependency and connects individuals, families and communities to the wider economy. Flow-on benefits include the enabling of healthy norms and routines for community members and their families. Investment in ACCHSs has a multiplier effect in communities beyond the critical improvements in health that they deliver" (CtGSC 2014).

ACCHS provide a channel for employment and economic growth in communities. As a relatively large-scale employer of Aboriginal people and the main source of employment in many communities, an investment in ACCHS would generate a range of local, regional and national multiplier effects, as an initial investment leads to more jobs and more income, which creates more jobs and income, and so on. The multiplier effect refers to the increase in final output (employment, income, GDP) arising from any new injection of spending.

ACCHS employment examples

Kimberley Aboriginal Medical Services Council, a regional collective of ACCHS throughout remote north-west Australia, has multiple clinics across the Kimberley region including remote clinics and renal services. KAMSC is a major employer in the Kimberley region. Aboriginal people represent more than 70% of its 300+ strong workforce.

Rumbalara Medical Centre in rural Victoria employs about 55 Aboriginal staff in its Medical Centre and 153 in the Rumbalara Aboriginal Cooperative overall. This represents about 11% of all Aboriginal employment in the area and 31% for the Co-operative as a whole.

Australian research indicates that by industry sector, education multipliers tend to be the highest, followed by health (2.1) and community services (North Australia Research Group 2010; Stoeckl et. al. 2007). Health economics research suggests that a 1.62 multiplier effect on employment and 1.6 on income from an initial investment is a reasonable, low end of the range of health multipliers. That is, for every additional job created or dollar invested, an additional 0.62 jobs and 0.6 more income would be generated (secondary effect). [4] The final, longer term impact (induced demand) would be greater again as the cumulative effects of additional employment and income generate additional new investment (Stoeckl et. al. 2007; Doeksen & Schott 2003; KY Rural Health Works 2003).

An expansion of the Aboriginal health sector in particular could do more to promote regional development than an equal expansion of other sectors. It is a particularly cost-effective investment owing to the relatively small size of the Aboriginal population and labour market and the flow-on effects beyond health to other industry sectors.

To illustrate these multiplier effects, assume that government allocates funding to ACCHS that doubles the existing ACCHS workforce,[5] and a conservative employment multiplier of 1.62. The results are presented as a three-stage process presented in Table 18.

Table 18 Multiplier effects of doubling the ACCHS workforce on Australian Aboriginal and Torres Strait Islander employment

Measure	AUST Aboriginal and Torres Strait Islander employment	AUST Aboriginal and Torres Strait Islander unemployment	AUST Aboriginal and Torres Strait Islander Unemployment	ACCHS Aboriginal and Torres Strait Islander employment (i)
	no.	no.	%	no.
1 Existing employ't/unemploy't	147,708	30,460	17.1%	**3,215**
2 Initial effect (ACCHS employ't doubled) (iii)	150,923	27,245	15.3%	6,430
3 Secondary effect (x 1.62)	244,495	0	0%	10,417 (ii)
Change from 1 to 3 (%)	**↑ 65.5%**	**no unemployment**	**0%**	**↑ 224%** (ii)

Sources: census 2011**;** Table 16; Stoeckl et. al. 2007; Doeksen & Schott 2003; KY Rural Health Works 2003.
Notes
(i) An estimated 3,215 of the estimated 5,829 ACCHS employed workforce are Aboriginal.
(ii) Additions to ACCHS employment after the initial effect would depend on government rather than market decisions.
(iii) The employment multiplier of 1.62 is smaller than suggested in the literature. A larger multiplier would obviously generate stronger effects. [4]

[4] Technical note: A 1.6 - 1.62 multiplier is consistent with previous Australian government fiscal expansion multipliers for additional expenditure effects on GDP and employment (Australian Government 2008-2009). Multipliers have several restrictive assumptions (ABS multiplier 2013). Other multiplier evaluations include public investment in regional Australia (4.75 multiplier), Australian tourism (1.9; Gretton 2013:7-8). The ACCHS investment multiplier is probably higher than 1.6.

[5] The Australian Health Ministers Health Performance Framework supports a target of at least **2.7%** of Aboriginal and Torres Strait Islander employees in the public health sector by 2015. To achieve this would require over **6,000** more Aboriginal health professionals (Mason 2013: 185-188, 195; 2011 census).

The ACCHS multiplier in Table 18 is an impact multiplier and does not add in longer term induced demand or final impact multipliers, such as induced investment in capital equipment and other investment effects.

The time frame for short-run impacts may be less than two years and longer for final impacts to flow through the region. The time frame will be shorter in smaller regions (Mandelbaum & Chicoine 1980). In the case of ACCHS, longer run investment effects may include the establishment of multiple-function Aboriginal co-operatives around ACCHS and improved housing stock. Table 18 does not include equity or externality type benefits that are additional to direct market benefits.

The e*conomic benefits of the multiplier effects* of additional investment in employment and future workforce capacity building will be limited if ACCHS infrastructure needs are not meet, that is, supply-side constraints may exist (Gretton 2013: 6).

Table 18 indicates secondary effects of a 66% increase in Aboriginal employment. High national unemployment rates would be initially reduced by 1.8% with the potential for full employment as the ripple effects of the stimulus spread through communities.

More generally, there are a range of potential economic benefits from an additional investment in ACCHS:

• *Employment*
The COAG Aboriginal employment target continues to lag (PM 2014). An injection of funds into existing and new ACCHS would substantially increase skilled, sustainable employment for Aboriginal people, including in regions without established labour markets and viable alternative employment opportunities for Aboriginal people. The case studies for this Report indicate **substantial employment and income benefits for regional communities** (Section 3). **Endemic passive welfare dependence and high unemployment rates for former CDEP workers could be overcome by an additional investment in community-based primary health care jobs.**

• *Education*
ACCHS employment and further education and training are strongly linked. Employment is predominantly in skilled occupations. This increases the education and skill base of the Aboriginal workforce. ACCHS provide local traineeships as AHWs and Aboriginal Health Practitioners. Additional funding could be a vehicle for skilling up and employing former CDEP workers, who currently contribute to high unemployment rates (PM 2014).

• *Income*
ACCHS employee wages and salaries are higher than the average for Aboriginal Australians. There is a strong relationship between lower income and poorer health among Aboriginal Australians (AHMAC 2012). Wages and salaries are not the main source of income for most Aboriginal adults (ABS census 2011; Biddle 2013). The multiplier effects of ACCHS income from wages and salaries are substantial in neighbourhoods and communities, as indicated in Section 3. An investment in ACCHS may offset the adverse effects on Aboriginal people of high prices and unaffordable housing in mining communities (Hunter 2013).

• *Regional benefits*
The effects would be relatively greater in local communities with small or non-existent mainstream labour markets and low incomes.

• *Remote area benefits*
There is a strong economic case for increasing community capacity by investing in resident Aboriginal primary health care teams, with training, funding and infrastructure support and strong

relationships with the community. Visiting health professional services are increasingly used to deliver health care. Fly in/fly out (FIFO) or drive in/drive out (DIDO) services may not improve equity of access to services and should not be used as a substitute (H of R 2013; Wakerman et. al. 2012).

• *Cross-sector multiplier benefits*
These would be substantial, given the strong relationship between Aboriginal health, education/training, employment, economic independence (ending welfare dependence) and high value-adding from investing in education/training in particular. Aboriginal education policies tend to obscure access and resourcing issues and the fundamental importance of employment and economic independence. Promoting skilled employment and private income would flow on to improved outcomes in other COAG building blocks.

• *Inter-generational benefits*
These are a longer term but feasible outcome from increasing sustainable employment, economic independence and the positive role model effects of skilled working Aboriginal people on families, communities, and on young people in particular.

• *Improved health and reduced government health care costs*
Promoting access to culturally appropriate primary health care via ACCHS would reduce the costs of providing mainstream primary health care and expenditure on expensive hospital-based services.

• *Improved government budgets*
Deloitte Access Economics estimates the scale of strengthening in government budgets that would flow from increasing Aboriginal employment and productivity, as well as from raising life expectancy over a twenty-year time period from 2013. These include:

* $11.9 billion net increase in government revenue over 20 years (mainly tax payments from increased employment).
* $4.7 billion less government expenditure on social security and health.
* Biggest savings would be expenditure on justice (↓ 89%), social security (↓ 54%) and health (↓ 33%; Deloitte Access Economics 2014).

• *Economy-wide benefits*
Achieving equity in employment and health outcomes would increase GDP/national income over a twenty-year period by 1.2% higher in real terms — equivalent to around $24 billion (Deloitte Access Economics 2014). This is a reasonable estimate in view of comparable evaluations (Gretton 2013:7; see Section 2.1).

• *Promoting government policy outcomes*
Increasing the capacity of ACCHS, employment, education/training and income gains, to individuals, families, communities, regions and the national economy would generate substantial flow-on effects on *Closing the Gap* targets.

In sum, **additional investment in ACCHS is a cost-effective multi-sector strategy** that would generate a **range of local, regional and national health and cross-sector multiplier effects.** Strategies aimed at achieving improvements in any one area will not work in isolation (Deloitte 2014; ROGS 2013: 2.11; DSS 2012). Investing in ACCHS is highly effective in meeting government policy goals and targets.

Section 2 Aboriginal Primary Health Care Services (PHC) and Aboriginal Community Controlled Health Services (ACCHS): the evidence

Section 2 summarises service, client, staff and expenditure for Aboriginal and Torres Strait Islander primary health care (PHC) services, followed by a summary of ACCHS, workforce issues and evaluations.

Tables 13-17 provide relevant information on Aboriginal primary health care services (PHCs) and ACCHS:

- Aboriginal PHCs: key measures, Australia, 2008-09— 2011-12 (Table 13).
- Aboriginal Community Controlled Health Services - ACCHS: key measures, Australia, 2012-13 (Table 14).
- ACCHS: selected health-related services, Australia, 2012-13 (Table 15).
- ACCHS: workforce, ACCHS employment estimates, Australia , 2012-13 (Table 16).
- ACCHS: workforce, main staff types, Australia, 2012-13 (Table 17).

Table 13 Aboriginal Aboriginal Primary Health Care (PHC) Services: key measures, Australia, 2008-09 — 2011-12

Measure		2008-09	2011-12	2008-09 to 2011-12 change %
Services	(no.)	205	224	↑ **9%**
Clients [(i)]	(no.)	347,858 (294,126 ATSI)	445,419 (350,335 ATSI)	↑ **19%**
Episodes of care	(no.)	2,095,915	2,620,839	↑ **25%**
Client contacts	(no.)	2.6 million	3.5 million	↑ **34.6%**
Staff FTE	(no.)	**E 4,537** [(v)] (57% ATSI)	**E 5,618** [(v)] (57% or 3,168 ATSI)	↑ **23.8%**
Aboriginal and Torres Strait Islander pop'n AUST	(no.)	E 642,676	E 685,149	↑ **6.6%**
Aboriginal and Torres Strait Islander PHC clients as proportion of pop'n [(iv)]	**(%)**	E 46%	E 51%	↑ **5%**
Ratio of services to pop'n		**1: 3,135**	**1: 3,059**	↑ **2.4%**

Sources: AIHW HSR 2013, 2010; ROGS 2013: Table 11A.12; ABS 2009; census 2011, 2006.
Notes
E = Population estimates are backcast from 2011 census using growth rates from ABS Demographic Statistics 2013.
(i) Client numbers are under-estimated. See Section 2.1.
(ii) Episodes of care exclude transport services.
(iii) *Client contacts:* All individual client contacts made by each type of worker involved in provision of health care by the service.
Episode of health care: Contact between a client and a service by one or more staff to provide health care (AIHW).

(iv) Staff estimates adjusted for incomplete reporting by PHC services; AIHW HSR 2013: 4, 11; 2010: 10. Estimates of the proportion of the Aboriginal population using Aboriginal PHC services and ACCHS range. The above estimate is conservative. Alternative estimates are 60% and 61% (AIHW HSR 2013; Deeble 2009; See Section 2.1).
(v) 57% of staff are Aboriginal, with no change in the Aboriginal proportion of staff during the period.

Table 14 Aboriginal Community Controlled Health Services - ACCHS: key measures, Australia, 2012-13

OSR service item	no.	Aboriginal and Torres Strait Islander clients %
CS-1 Episodes of Care	2,519,798	85
CS-3A Individual clients	341,858	82
CS-4 Health assessment, plans (inc.chronic disease)	103,853	na
CS-2 Clinical activities by:		
AHW	523,636	91
Aboriginal and Torres Strait Islander Health Practitioner	39,059	96
Doctor - General Practitioner	1,168,055	83
Nurses	867,334	88
Midwives	58,408	90
Dental / Dental therapist, support	123,008	87
Other clinical	241,998	90
Medical Specialists (11)	48,162	92
SEWB	127,687	95
Allied health	165,087	90
CS-2 Total clinical activities	3,362,434	88
Transport - not included in episodes of care	147,762	88

Source: NACCHO ACCHS annual OSR reports for 104 services, adjusted to 134 OSR reporting ACCHS. See Section 2.1.
Notes
OSR = Online Services Report to Indigenous and Remote Health Division (IRHD), Australian Department of Health.

Table 15 ACCHS: selected health-related services provided, Australia, 2012-13 (%)

Health-related services provided	Proportion of ACCHS providing service (%)
Substance use / drug & alcohol programs	**100**
Patient transport (all weekdays, & 31% additional AH service	**100**
Child immunisation	**97**
Mental health / SEWB services, including	**96**
Short term counselling	84
Home visits	81
Long term counselling	73
Group activities	67
Self-harm and suicide prevention	67
Keep track of clients needing follow-up	**92**
Routine STI screening /early detection	**88**
Arrange free provision of medical supplies/pharmaceuticals	**86**
Allied health (av. range 7 services, & facilitate referrals)	**66**
Services for people with a disability	**65**
Aged care	**64**
Palliative care	**57**
Dental assessment/ treatment	**56**
Medical specialist services	**34**

Source: NACCH0 ACCHS OSR data 2012-13.

Table 16 ACCHS: Workforce: ACCHS FTE employment estimates, Australia, 2012-13

Occupation	Aboriginal Aboriginal and Torres Strait Islander no.	Total ACCHS no.	Proportion Aboriginal and Torres Strait Islander %
1.1 CEO	95	130	73%
1.2 Managers, supervisors	320	707	45%
1.3 Admin/clerical	425	621	68%
1.4 Skilled non-health	120	394	30%
1.5 Ancillary, unskilled	385	503	77%
1.6 Admin. support, trainees, training	152	184	83%
1 Total managers, admin.support, trainee/training	1,497	2,539	59%
2 AHW/practitioner	778	791	98%
3 GP	30	382	8%
4 Medical specialist	0	41	0%
5 Nurse	94	611	15%
6 Midwife	8	88	9%
7 Dentist/therapist	7	75	9%
8 Dental assistant	50	88	57%
9 Allied health prof.	384	626	61%
10 SEWB	197	300	66%
11 Health promotion/prevent'n	105	153	69%
12 Other health prof .nei	54	100	54%
13 Miscellaneous	11	35	31%
TOTAL	**3,215**	**5,829**	**55%**

Source: NACCH0 ACCHS OSR data 2012-13.

Note: Full-Time Equivalent - a standardised measure used in converting number of persons in part-time employment to full-time employment.

Table 17 ACCHS Workforce: main staff types and Aboriginal and Torres Strait Islander proportion, Australia 2012-13

Staff types	Aboriginal and Torres Strait Islander proportion %
Non-clinical staff	59%
Clinical staff	51%
Snr managers	45%
CEO	73%
Total	55%

Source: as for Tables 15 and 16.

Notes

Tables 16 and 17 workforce estimates are based on adjusting data available for 104 services to 134 reporting services to OSR. Estimates include an estimated 190 FTE staff, about 3% of all

employment, whose wages/salaries were externally funded i.e. not by ACCHS.

2.1 Data limitations

ACCHS-specific data is not available in AIHW OSR and other government reports on Aboriginal primary health care services. ACCHS-specific data from government Online Services Reports (OSR) was first provided to NACCHO in 2013. It is summarised for the first time in this Report, including client numbers, episodes of care, health-related activities and staff.

117 ACCHS reported to government (OSR) in 2010-2011 (AIHW ACCHS 2013: 9). Currently there are 150 ACCHS with up to 300 outreach clinics. Of these, 134 ACCHS are independent ACCHS. Data and estimates presented are adjusted for these 134 independent services.

The Report relies on AIHW and ROGS expenditure data. There are discrepancies between them, some quite large for 2010-11. A small part of the difference in per capita expenditure is due to different population numbers. Additionally, State/Territory expenditure on ACCHS is not available.

ACCHS-specific government expenditure is not available for the States and Territories. A *'first guess'* conjecture is that ACCHS *may* account for *about 13%* of all government Indigenous health expenditure. This estimate should not be relied on and more detailed ACCHS-specific expenditure data is required to enable precise calculation of the relative size, in fiscal terms, of the ACCHS sector. (2)

Incomplete identification of an estimated 39% of Aboriginal and Torres Strait Islander people in health records results in understating client numbers and the overall volume of primary care delivered by ACCHS (Deeble 2009). This Report estimates the proportion of clients to population is, at a minimum, 51% (Table 13). This is much lower than other estimates of 60.2% and 61% (AIHW HSR 2013; Deeble 2009).

Reasons for under-estimation include incomplete identification of Aboriginal status in service records, and reporting annual clients rather than all clients. The proportion of clients recorded as of unknown Aboriginal status is substantial. Adjustments based on reasonable assumptions increase the proportion of Aboriginal people using ACCHS by an estimated 15% (Professor John Deeble 2009).

For these reasons, this Report notes that **the proportion of the Aboriginal and Torres Strait Islander population who are annual clients of Aboriginal PHCs and ACCHS is estimated at between 51% and 61%.**

This Report is the first ACCHS-specific health economics study in Australia. It draws on extensive health and health economics research literature. Further research would help to fully quantify the range of economic benefits of ACCHS.

2.2 Aboriginal and Torres Strait Islander primary health care (PHC) services, 2001 —2011-12 (Tables 3-5, 7-10, 12, 13)

In 2000 a *House of Representatives committee inquiry into Indigenous health* recommended that the Australian government commit increasing (financial) resources to the ACCHS sector, increase Aboriginal community control over Aboriginal Health Services and ensure that they were not financially disadvantaged from health sector recommended reforms. The Government of the day accepted these recommendations (H of R 2000; Government Response 2001).

The share of all government expenditure for Aboriginal PHCs and ACCHS kept pace with overall Indigenous health expenditure in the years to 2010-11 (Table 3). However, **a large reduction in Indigenous health expenditure in 2012-13 will be followed by projected further reductions in the next three years of 0.7% annually on a per capita basis** (Table 4.2). Section 1 summarises funding issues.

Trends in population growth compared with the growth in Aboriginal PHCs between 2001-02 and 2010-11 and key measures regarding Aboriginal PHCs between 2008-09 and 2011-12 are summarised in Tables 9 and 13. Data in these Tables may be compared with data on trends during the same period in Aboriginal visits to GP/specialists, dentists and hospital casualty/outpatients in Table 11.

These Tables indicate:

• **Proportionately more Aboriginal people are using Aboriginal PHC services** (1.7% annual increase in the three years to 2011-12). **Increasing demand** (measured by client growth) by 6.3% annually over the last three years **has more than doubled population growth.**

• **Service growth of 3% a year failed to match increasing demand** over the last three years. An annual 12% increase in client contacts and 8% in episodes of care indicates growing intensity of service use and strains on ACCHS capacity (see Table 3 note (iii) for definitions of episodes of care and client contacts).

• Limited service growth compared with increasing demand, episodes of care and client contacts has placed increased pressure on PHC staff.

• **There has been a trend towards increasing use of and demand for Aboriginal PHCs compared with alternative mainstream health services over the last decade** (Tables 11, 13). Aboriginal PHCs client numbers increased by 6.3% annually in the last three years. Over the past twelve years, there has been little change in the proportion of the Aboriginal population visiting GP/specialists (0.01% annual increase) and hospital casualty/outpatients (0.1% annual decrease) in the previous two weeks.

• Government health reports tend to highlight negative features of Aboriginal health such as increasing hospital expenditure. They give less attention to the substantial contribution made by Aboriginal PHC services and ACCHS to primary health care, and to reducing strains on mainstream primary and possibly also secondary health care services.

In sum, it appears that **increased reliance is being placed on ACCHS to support the primary health care needs of Aboriginal people, notwithstanding a trend towards mainstreaming Indigenous health expenditure and projected declines in per capita expenditure** (Tables 4.1, 4.2, 5; Section 1.7.3).

A summary of Aboriginal PHC services services, clients, episodes of care, staff and population increases between 2008-09 and 2011-12 is presented in Table 13.

• *Services*

Government budget estimates for **2013-14 note that approximately 275 organisations will be funded to provide comprehensive primary and allied health care services to Indigenous people** (Australian Government Budget Papers 2013. Outcome 8 Indigenous health: 154-5). **It is not known whether these are mainstream or Indigenous-specific services.**

A rapidly increasing Aboriginal population means that relatively few services are catering for many more people (Table 13). Further, **in 2011-12 the number of services declined from 235 the previous year to 224 and staff numbers also fell**, for unknown reasons AIHW HSR 2013: 97).

Supply shortages of Aboriginal health services nationally are acknowledged by the Australian Health Ministers (AHMAC 2012: 157-8).

The range of services provided is much broader than those provided by mainstream primary health care providers. As well as individual clinical care activities and referrals to allied health and specialist medical services, Aboriginal PHC services include range of screening, population health, broader health-related and community services (AIHW HSR 2013; AIHW ACCHS 2013).

Within the constraints imposed by funding, services directly address the *Four A* barriers that impede Aboriginal people's access to mainstream health services — *Availability, Affordability, (Cultural) Acceptability and Appropriateness (to health need)*. Services bulk-bill, and include traditional health care, bush tucker and cultural promotion programs, Bringing Them Home and other Aboriginal-specific SEWB services, patient transport, welfare services, breakfast and nutrition programs (AIHW HSR 2013: 108-122).

The main constraints on service provision are funding and funding insecurity, workforce shortages, mainstream partnership issues and the administrative overburden imposed by competition for funding and meeting numerous regulatory and compliance requirements.

There are considerable variations in the supply of Aboriginal PHCs between States and Territories and geographical areas (Section 1.7. 6 iii, iv). Moreover, many struggle with limited clinical staff and over-reliance on Aboriginal Health Workers. 39% of all services have no doctor. Shortages are greater in major cities (AIHW 2013:101; ROGS 2013: 11A.13; Weightman 2013).

Case study

ACCHS Rumbalara Medical Centre in rural Victoria is part of the Rumbalara Aboriginal Cooperative. Its administration team deals with more than 90 funding agreements and compliance requirements that require approximately 423 reports annually.

Health research indicates that a particularly onerous overall funding and regulatory burden imposed on the Aboriginal primary health care sector strains its capacity to deliver comprehensive primary health care (Lowitja Institute 2012).

- *Annual clients*

Reported client numbers represent annual visits, hence under-enumerate the total client population by excluding clients from previous year(s). (See Section 2.1). 445,419 Australians were clients of Aboriginal primary health care services in 2011-12, an increase of 19% over the last three years. About 80% of clients are Aboriginal.

- *Client contacts and episodes of care*

3.5 million client contacts and over 2.6 million episodes of care in 2011-2012 representing 35% and 25% increases respectively over the past three years. This extraordinary growth dwarfed service growth (see Table 13 note (iii) on distinction between client contacts and episodes of care).

- *Staff*

Full-Time Equivalent (FTE) staff increased by 7.9% annually over the three years to an estimated 5,618 staff in 2011-12 (including 53 externally paid staff; Table 13). About 57% were Aboriginal, a proportion that did not increase over the period. In 2012, staff numbers were reduced by 4.2%

(ROGS 2014 Table 11A.18). Increasing clients, episodes of care and client contacts have placed more pressure on staff amid limited health infrastructure and physical resources in the sector.

• *Jurisdictional and geographical distortions in distribution of Aboriginal PHC resources* (Tables 5, 7, 9, 11)

Funding and expenditure patterns by jurisdiction and remoteness are discussed in **Section 1.**

• *Clinical shortages*

Over one-third (38.7%) of all Aboriginal PHC services do not employ a doctor. Shortages are worse in non-remote areas. There has been little change in the proportion of Aboriginal people recently visiting a GP or specialist over the past twelve years. After-hours GP services are much lower in areas where Aboriginal people are a higher proportion of the population (AIHW HSR 2-13: 101; ABS 2013; AHMAC 2012: 155).

2.3 Aboriginal Community Controlled Health Services, 2012-13 (Tables 14-17)

• *Services*

150 ACCHS represent up to 300 clinics across Australia. 134 services report annually to the Australian Department of Health (OSR; see Section 2.1).

Two-thirds (66%) of all clinical activities are conducted by GPs, nursing and dental staff, a further 16% by AHWs/health practitioners and 17% by allied health and program-specific staff such as drug and alcohol staff. Only 1% of health activities directly involve medical specialists (Table 15).

Selected health-related services provided by ACCHS (Table 15) include a broad range of services that extend well beyond individual health-related services, including group, social welfare and community services. Barriers to access including cost and transport are addressed by all ACCHS providing patient transport when needed and the majority (86%) arranging for free provision of medical supplies and pharmaceuticals. While mainstream GPs find it hard to monitor and follow up Aboriginal clients, 92% of ACCHS provide this service.

Service limitations are noted in Section 2.2 services.

• *Clients*

ACCHS serve a client population of an estimated 341,858 people a year, 82% of whom are Aboriginal (Table 14).

• *Episodes of care and clinical activities*

An estimated 2.5 million episodes of care and 3.4 million total clinical activities for 341,858 clients in 2012-13 indicates the complexity of Aboriginal health needs and range of clinical diagnostic and treatment procedures required (Table 14). This would not be possible in many mainstream settings.

• *Staff (Tables 15, 16)*

In 2012-13, ACCHS employed an estimated 5,829 FTE staff including about 190 externally funded staff. 55% were Aboriginal, proportionately more in non-clinical (59%) than clinical occupations (51%). Non-clinical staff estimates are lower in government reports (AIHW E 2013: 99; ROGS 2014 Table 11A18). CEOs tend to be Aboriginal (73%), but senior managers less so (45%). Most

Aboriginal health workers/health practitioners (98%) and administration support and trainees (83%) are Aboriginal.

• *Professional profile and workforce development*

ACCHS employment differs from overall Aboriginal and Torres Strait Islander employment in its professional content. 17% of employed Aboriginal Australians work as labourers (compared with 10% of the total Australian population) and 13% as professionals (22% total; ABS 2011 census). By contrast, most ACCHS staff members have tertiary education qualifications or are in the process of attaining them, and many have multiple tertiary qualifications (NSW ACCHS 2013; Noetic Solutions 2012). The ACCHS workforce professional baseline is Certificate III in Aboriginal and Torres Strait Islander Primary Health Care.

Organisational pathways in the ACCHS sector require tertiary education and training and many ACCHS employ local trainees. NACCHO has links with the Aboriginal and Torres Strait Islander Health Registered Training Organisation National Network (ATSIHRTONN). With adequate resourcing this could enable the further development of skilled capacity in the ACCHS health workforce as part of the NACCHO *Ten Point Plan 2013-2030.*

2.4 ACCHS workforce issues

"Increasing the size of the Aboriginal and Torres Strait Islander workforce is fundamental to closing the gap in Indigenous life expectancy" (Australian Health Ministers in AHMAC 2012: 145).

• **Supply constraints**
Limited growth of ACCHS to cater for a rapidly increasing population in all regions of Australia imposes considerable strains on staff and health infrastructure. The burden on AHWs in particular in services lacking GPs and allied health professionals is substantial.

• **Under-representation in health workforce**
Aboriginal and Torres Strait Islanders are 3.0% of Australia's population but only 1.8% of the health professional workforce and 0.3% of the medical workforce (GPs and medical specialists; AIHW WF 2014:11; Mason 2013: 188).

• **Concentration** in non-clinical and administration areas
Aboriginal and Torres Strait Islander people are particularly under-represented in medical practice, dentistry, nursing, midwifery and to a lesser extent in allied health professions (Mason 2013: 187; Table 17).

• **ACCHS workforce shortages**
Difficulties attracting and retaining health professional staff are perennial issues. General health professional workforce shortages, particularly of nurses, and doctors to a lesser extent, may aggravate the problem (HWA 2012). Workforce education/training, attraction and retention strategies and additional funding is needed (Mason 2013).

• **Aboriginal health workers (AHWs)**
AHWs are a significant portion of the Aboriginal PHC workforce and play a critical role, particularly in services lacking clinical staff. AHWs report a range of workforce issues, including low status, stress and burn out, lack of respect for their cultural knowledge, barriers to training including travel and racism and discrimination in the work place (Mason 2013; HWA 2011; AWHNTC 2010: 30-33; AWHNTC 2009: 17, 25-27).

• **Patchy, uncoordinated work health workforce training sector** (Mason 2013)

High value-added impact from education/training spending is the key to healthy futures. A more collaborative and coordinated approach is needed to increase Aboriginal people's participation and completion of training in the Australian health workforce. This is fundamental to achieving better health outcomes. The *Review of Australian Government Health Workforce Programs* identifies recruitment, training and support for Aboriginal and Torres Strait Islander staff as a top priority (AIHW survey in NACCHO 2013; Mason 2013).

• **Wages gap**
On average, Australian Aboriginal and Torres Strait Islander males earn 22% less than non-Aboriginal males, and females 14% less (ABS 2011 census; Deloitte Access Economics 2014: 47). Pay differences between the Aboriginal and non-Aboriginal health workforce are substantial, with reported differences in position and training as well as in pay between mainstream and Aboriginal health workers (research cited in Hunt 2013). The median range of salary for Aboriginal employees in New South Wales ACCHS is $41,000 – $50,000 and is $20,000 lower than for non-Aboriginal employees. Aboriginal employees are largely under-represented in higher clinical roles that offer higher salaries (NSW ACCHS 2013).

One result is the 'brain drain' from ACCHS to pursue better career opportunities and/or higher remuneration packages (NSW ACCHS 2013). Funding insecurities including short-term and pilot programs may aggravate this trend (Lowitja Institute 2012).

• **Partnerships**
Mutual capacity building may occur in partnerships but significant support is needed to build capacity through training, local workforce development and mentoring of staff. Successful and respectful partnerships emphasise transfer of resources, leadership and responsibility for service provision to Aboriginal partners (Burton 2012 in Hunt 2013).

• **Workforce targets**
There has been no increase in the Aboriginal proportion of staff (55%-57%) in Aboriginal PHCs over the past three years at least. Government and COAG employment targets are not being met (PM 2014; CtGSC 2014). The Australian Health Ministers Health Performance Framework supports a target of at least **2.7%** of Aboriginal and Torres Strait Islander employees in the public health sector by 2015 (Mason 2013: 185, 195). **To achieve this would require approximately 6,887 more Indigenous health professionals** (2011 census; Mason 2013: 185-188).

CAEPR (the Centre for Aboriginal Economic Policy Research) recommends explicit Aboriginal and Torres Strait Islander employment goals for government programs that deliver goods or environmental or personal services. (Gray et. al. 2012). Aboriginal women have expressed reservations about job quotas and Aboriginal-designated positions that may reinforce segregation of the Aboriginal health workforce (AWHNTC 2010: 32-33; 2009, passim).

2.5 Evaluating ACCHS: government general performance indicators (Appendix 1)

Equity: access

• Access to services is critical and where ACCHS exist, the community prefers to and does use them, suggesting patterns of use reflect patchy supply (Panaretto et. al. 2014).
• Delayed or avoided early interventions and survey evidence indicate barriers to primary health care services, and that many Aboriginal people do not regard mainstream primary health care services as acceptable, appropriate substitutes for ACCHS.
• *Four A Barriers — Availability, Affordability, (Cultural) Acceptability and Appropriateness (to health need)* — are directly addressed and access enhanced by a range of ACCHS services that are rarely if ever provided by mainstream primary health care services — for example, **all services provide patient transport when needed, 92% track clients needing follow-up, 86% arrange**

free provision of medical supplies/pharmaceuticals, as well as a range of group and community services (research cited above, Section 3 case studies and Table 15).

• ACCHS mental health services are highly culturally competent, and they cater for widespread inter-generational trauma and high rates of psychological distress by *Bringing Them Home, Link Up* and other SEWB services. These are linked to alcohol, drug and substance misuse services and prison health (NACCHO 2013 data).

• ACCHS and other Aboriginal PHC services provision of substantial increases in client contacts and episodes of care are indicators of improved access as a result of providing culturally appropriate services (Tables 13, 14).

• The ACCHS hub and spoke model of delivering primary health care services is unique and effective. 150 ACCHS services across Australia operate up to 300 ***outreach services*** for smaller and more dispersed communities.

• **Comparisons between the cost of using a mainstream GP as opposed to an ACCHS are not particularly useful or valid** (Panaretto, Wenitong, Ring, Button 2014). The ACCHS model is based on a multi-disciplinary team dealing with complex health needs that combines professional and clinical expertise with a culture and community-based approach. Equitable access may be better measured using (culturally) appropriate methods of health service delivery for the target group (Vos et. al. 2010; Ong et. al. 2009).

Quality of services

• The Community Controlled sector can play in closing the gap in Aboriginal and Torres Strait Islander health outcomes by leading the use of clinical data to record and assess the quality of services and health outcomes (Panaretto et. al. 2013).

• Care delivered in ACCHS for prevention and chronic disease management appears to be equal to if not better than that delivered by general practices (Panaretto et. al. 2014).

• Demonstrable sound governance arrangements, responsive to local community needs (AHMAC 2012: 147).

• GPs report an increase in Aboriginal patients with chronic and complex needs, who overall have longer consultations compared with other patients (University of Sydney 2013; AIHW 2012: 98). **Aboriginal medical services treat patients with more complex problems** and strengthening these services should be a priority for governments (AHMAC 2012: 157; Osborne et. al. 2013).

Equity: outcomes

• Indigenous-specific primary health care services improve control of communicable diseases, increase screening for cancer, provide early detection resulting in reduced complications from chronic diseases and mental illnesses, improve child and maternal health outcomes and reduce social and environmental risks such as alcohol consumption and injury (Queensland Government 2011; Panaretto et. al. 2007).

• Effective chronic disease programs in local Aboriginal communities include reduced mortality and renal failure from systematic screening and treatment programs (Hoy et. al. 2003).

• Community-initiated and managed healthy lifestyle programs in remote and urban Aboriginal communities improve coronary heart disease risk factors related to diet (CtGC 2013). "***An Aboriginal and Torres Strait Islander community controlled health organisation is an ideal location for managing cardiovascular health and provides a setting conducive to addressing a broad range of chronic conditions***" (Australian Government NATSIHP 2013).

• Asthma education programs for parents and carers conducted by Aboriginal Health Workers leads to fewer school days missed due to wheezing (CTGC 2013).

• Mainstream anti-smoking campaigns tend to be ineffective in Aboriginal communities (Alford 2004). A 7% national decline in the proportion of the Aboriginal population smoking over the past eleven years is linked with ACCHS successful anti-smoking health promotion programs (ABS Health 2013; ACCHS reports 2013).

• ACCHS outperform mainstream services in terms of treatment and prevention (Panaretto, Wenitong, Ring, Button 2014).

Better health outcomes are ensured by providing holistic care, responding to individual, family and community social issues and the underlying determinants of health alongside quality health care (Osborne et. al. 2013; AHMAC 2012: Tiers 1 & 2; Vos et. al. 2010).
• ACCHS have a number of horizontal cross-agency and cross-sector external benefits that are additional to direct market (employment and income) benefits indicated in Sections 1.10 and Table 18. Cross-sector benefits include increasing employment, education and skills, cross-cultural communication and awareness, community capacity, functioning and safety.
• Inequitable health outcomes are a drain on government budgets. Cost savings of of about $2,770 million a year would result from equitable health outcomes between Aboriginal and non-Aboriginal Australians.

Appropriateness

• Increasing preference for and use of ACCHS and PHCs reflects their cultural safety and competence, compared with the lack of cultural competence in many mainstream health services (Panaretto et. al. 2014; AHMAC 2012: 135-8).
• Most ACCHS have AHWs. They improve the cultural security of health care provided, help reduce the number of hospital discharges against medical advice and increase participation in health care activities (research in AHMAC 2012: 135; HWA 2011).

Appropriate and effective

• *"ACCHSs provide a model for the community control of other health services and sectors"* (research cited in CtGSC 2014; Rowley et. al. 2008).
• ACCHS are a significant (and under-used) intellectual and cultural resource on Aboriginal health matters.
• ACCHS respond flexibly to local community concerns and needs, and are often part of larger community organisations that perform broader health-related social functions such as housing (CtGSC 2014; *Russell 2013;* AHMAC 2012: 147; Section 3 case study Rumbalara).
• Aboriginal community-controlled services and programs provide potentially effective strategies for enhancing social and emotional wellbeing and addressing suicide risk factors, especially among young people (CtGSC 2014; Rowley et. al. 2008).
• The fundamental principles of local community governance and autonomy in decision-making can make a significant difference to Indigenous health and well-being (Panaretto et. al. 2014; Osborne et. al. 2013; QAIHC 2013; Russell 2013; Weightman 2013; Taylor et. al. 2012; Scrimgeour & Scrimgeour 2008; WHO 1978).
• **A major influence on the poor health of Indigenous Australians is their marginal position in relation to mainstream society. International health studies indicate that creating conditions that enable people to take control of their lives improves health outcomes** (Osborne et. al. 2013; Marmot 2011).

Efficiency: allocative and dynamic efficiency

• Cost-effective evaluations of 150 preventive health interventions and specific Aboriginal community-based and controlled health programs indicate that service delivery by ACCHS would lead to greater health gains from improved Indigenous access to health services via greater utilisation of services and adherence to treatment (Vos et. al. 2010).
• Increasing reliance on Aboriginal PHC services and ACCHS reduces strains on mainstream primary health care and considerably more expensive hospital-based services (evidence throughout this Report).
• ACCHS are both cost-effective and cost-efficient. They deliver value for money and are based on a combination of local knowledge, culture and health professional skills (Panaretto, Wenitong, Ring, Button 2014; Russell 2013; Bell et. al. 2000).

• Investing in ACCHS capacity building is a cost-effective multi-sector strategy that generates multiple benefits across sectors and communities. Strategies aimed at achieving improvements in any one area will not work in isolation (Deloitte 2014; ROGS 2013: 2.11; DSS 2012).

Effectiveness

• Health services focused on body parts and clinical specialties are unlikely to be as effective as those offering a range of primary health care services in one place (Bell et. al. 2000).
• Holistic approaches that take into account the full cultural, social, emotional and economic context of Indigenous peoples, including an awareness of the ongoing legacy of trauma, grief and loss associated with colonisation (Osborne et. al. 2013).
• Community-based public health and population health activities are effective (Bell et. al. 2000).
• Collective community-governed control of health services promotes engagement (Taylor & Thompson 2011, Coombe et al. 2008, in GtGC 2013).

Effective and appropriate

• Partnerships with Aboriginal organisations within a framework of Aboriginal self-determination, control and Indigenous-driven priorities works (GtGC 2013; research cited in Hunt 2013; Osborne et. al. 2013).

Ineffective and inappropriate

• Short-term funding and not continuing to fund programs that have demonstrated success can contribute towards Indigenous people feeling loss, disappointment and anger at being let down by the system (Osborne et. al. 2013).
• Without genuine engagement of Aboriginal people it will be difficult to meet the Council of Australian Government targets for overcoming Indigenous disadvantage.
• Staff operating on assumptions about the Aboriginal community and failing to recognise language differences and diversity within Aboriginal communities (research cited in CtGC 2013; Hunt 2013).
• Not training and employing Indigenous staff to contribute towards program implementation and delivery (Osborne et. al. 2013).
• Governments failing to address power inequalities, expecting Aboriginal people to function in western bureaucratic forms and style, and favouring western over Indigenous knowledge.
• Racism embedded in organisations, institutions and in individual attitudes and practices.

Effectiveness in meeting government policy goals and targets

• More collaborative working relationships between government agencies and other relevant organisations in delivering services and programs, acknowledging the interrelatedness of key social and economic determinants across multiple life domains for Aboriginal Australians (Osborne et. al. 2013).

• ACCHS rate well against *Health Performance Framework* performance measures (AHMAC 2012):

Tier 1 Health status and outcomes
Tier 2 Determinants of health, notably health risk factors, community capacity, social and economic gains
Tier 3 Accessible, effective, appropriate, efficient, responsive, continuous, capable.

NACCHO recommends additional capital investment, funding and workforce capacity to enhance ACCHS capacity and sustainability, which is a *Health Performance Framework* Tier 3 measure. See **Recommendations.**

Section 3 Case studies of Australian ACCHS

Case studies of three ACCHS in different geographical areas across Australia illustrate the broad range of health-related services provided that extend well beyond individual clinical health care. ACCHS deal effectively with complex health needs in a culturally safe and trusted environment, notwithstanding funding and capacity constraints and workforce shortages. The contribution of ACCHS to regional Aboriginal employment and economic independence is substantial.

Information about the ARIA [(i)] (Accessibility/Remoteness Index of Australia) classifications and service size [(ii)] of each ACCHS is included.

The case studies are

- **Winnunga Nimmityjah Aboriginal Health Service**
  Narrabundah CANBERRA ACT Major cities ARIA 1

- **Rumbalara Medical Centre**
  Shepparton/Mooroopna VICTORIA Inner regional ARIA 2

- **Mulungu Aboriginal Corporation Medical Centre**
  Mareeba QUEENSLAND Outer regional ARIA 3

(i) ARIA — Accessibility/Remoteness Index of Australia (AIHW 2004)

The ARIA classification provides a better measure of remoteness of an area than other classifications. The ARIA index score is based on road distance from the closest service centres in each class. Road distance is a surrogate for remoteness and the population size of a service centre a surrogate for availability of services. The classes are as follows:

1 Major cities - highly accessible — relatively unrestricted accessibility to a wide range of goods and services and opportunities for social interaction.

2 Inner regional - accessible — some restrictions to accessibility of some goods and services and opportunities for social interaction.

3 Outer regional - moderately accessible—significantly restricted accessibility of goods and services and opportunities for social interaction.

4 Remote — very restricted accessibility of goods, services and opportunities for social interaction.

5 Very Remote — very little accessibility of goods, services and opportunities for social interaction.

(ii) Service size

QAIHC (Queensland Aboriginal and Islander Health Council measures service size by the number of regular patients. Small is less than 500, medium is 500-1,500 and large is > 1,500 (QAIHC 2013: 1.2).

Winnunga Nimmityjah Aboriginal Health Service

ARIA 1
Major cities
Highly Accessible—
relatively unrestricted accessibility to a wide range of goods and services and opportunities for social interaction

Narrabundah Canberra ACT

Catchment area, population and socio-economic profile

The 5,185 Aboriginal and Torres Strait Islanders in the ACT represent 1.5% all ACT residents (2011 census). Aboriginal population growth of 6.8% annually has been faster than in any other jurisdiction over the last five years and the rate is increasing (ABS census 2011, 2006). In general, Aboriginal people's level of education, labour force participation and employment is higher in Canberra than in other jurisdictions but remains substantially lower than that of non-Aboriginal ACT people. 9.6% of Canberra's Aboriginal workforce is unemployed (17.2% Australia; census 2011; ACT 2013).

Recent media reports highlight Aboriginal homelessness as a big issue in Canberra, having increased by 33% annually over the past five years. 57% of Aboriginal households rent rather than own their own home (30% for non-Aboriginal households). Along with other social determinants of health, the housing crisis may partly account for the comparatively poor health status of Aboriginal people in Canberra. 46% of Canberra's Aboriginal population has three or more long-term health conditions, compared with 33% for Aboriginal Australians on average. 11.5% have chronic illnesses compared with 10.7% of the Australian Aboriginal population (ABS 2013:7; ACT 2013; Cox 2013).

Aboriginal and Torres Strait Islander Canberrans access health services less frequently than those in most other jurisdictions. There is high demand for Winnunga services. Aboriginal people from neighbouring New South Wales use ACT services and programs (ACT 2013).

Winnunga Nimmityjah Aboriginal Health Service

Winnunga Nimmityjah Aboriginal Health Service is located in Narrabundah, an eastern suburb of Canberra. Winnunga started 25 years ago as a single room in central Canberra, and has gradually expanded to the comprehensive primary health care service it is today.

Weekday services are provided on weekdays and afterhours services twice a week from 2013 due to *"continuing requests from our clients who work fulltime and would like a culturally appropriate primary health care service to be available to them"* (Annual Report 2012-13).

Winnunga offers a range of clinical services including general practitioners, practice nurses, midwives, a child health nurse, dentists, psychiatrists, drug and alcohol workers, a psychologist, pharmacist, physiotherapist, dietician, podiatrist, and a range of visiting specialists. An extensive Social Health Team provides counselling, advocacy, social and emotional wellbeing support and health education. Winnunga runs a diabetes clinic, a smoking cessation program, a parenting group, men's and women's groups and healthy cooking groups. There is also a needle and syringe exchange

program, an opiate nurse, a youth diversion program, a home maintenance program and prison outreach. Transport is provided for Winnunga clients as required. Australian National University (ANU) medical students are placed at Winnunga for both clinical and research components of their curriculum. Hospital resident medical officers rotate on placements to Winnunga and training for GP registrars is ongoing. Winnunga is both AGPAL and QIC accredited. Winnunga is the peak Aboriginal health body in the ACT and provides advocacy at local, ACT and national levels.

Winnunga clients

In the 15 months to February 2014 82% (3,372) of 4,199 clients who visited Winnunga were Aboriginal and/or Torres Strait Islander. Winnunga provides the majority (87%) of Aboriginal and Torres Strait Islander health checks in the ACT (Figure) and provided 37,913 client contacts in 2012-2013, excluding transport (*Annual Report 2012-13)*. There are 84 general practices in Canberra. It is clear that many Aboriginal Canberrans bypass several mainstream GP services on route to Winnunga.

Winnunga sees around 4,000 clients a year, with 22% of clients coming from outside the ACT. A large proportion of non-ACT clients come from neighbouring Queanbeyan in New South Wales (NSW), which had an Aboriginal and Torres Strait Islander population of 1,137 in the 2011 census. *Funding for Winnunga does not take the NSW population into account.*

During the census year of 2011, Winnunga saw 44% of the ACT resident Aboriginal and Torres Strait Islander population (*Annual Report 2012-13*). Over the two-year period from July 2010 to June 2012, *56% of the ACT resident Aboriginal and Torres Strait Islander population visited Winnunga.* The Winnunga client population is young, with 28% aged less than 15 years and only 2% aged 70 years or older.

Health profile

The types of health conditions seen by Winnunga differ from mainstream general practice, reflecting complex health care needs. They align more with national Aboriginal health statistics than those for urban non-Aboriginal Australians (Flegg et. al. 2010).

Staff (June 2013)

62% of Winnunga 48.49 FTE staff at June 2013 were Aboriginal or Torres Strait Islander. A further 3.42 FTE staff were externally funded. Proportionately more Aboriginal staff were in non-clinical (68%) than clinical (54%) occupations.

Winnunga FTE employment **Occupation/function**	**Aboriginal and Torres Strait Islander**	**Non-Indigenous**	**Total**	**Not paid by ACCHS** [(i)]
CEO	1	0	1	
Manager/supervisor	3	3	6	
Driver, file officer	1	0	1	
Admin, finance, IT	7	3	10	
AHW	3	0	3	
GP	0	5.27	5.27	0.8

Nurse	1.93	1	2.93	1
Midwife	0	2	2	
Dentist/therapist	0	1	1	
Dental support	0	1	1	
Medical specialist	0	1.55	1.55	0.8
All allied health	0	0.74	0.74	0.82 (ii)
All SEWB	4	0	4 (iii)	
D & A, tobacco staff	4	0	4	
Other health worker	2	0	2	
Training position	2	0	2	
Home maintenance worker	1	0	1	
Total staff	**29.93**	**18.56**	**48.49**	**3.42**

(i) Externally funded staff.
(ii) Allied health staff include a pharmacist, physiotherapist, hearing, nutrition & diabetes staff.
(iii) SEWB staff include a Link Up caseworker, counsellor and psychologist.

Economic and social value

• *Employment and wages/salaries: Winnunga provides employment for thirty Aboriginal people and over 60 local jobs in total, with wages/salaries of $4.4 million annually.*

• *Revenue:* Total income is $7,763,217. 73% is from governments, 3% non-government grants, 17% from Medicare and the balance (7%) from other sources.

• *Capacity constraints*

Winnunga has grossly inadequate clinical space to house expanding services, resulting at times in inability to perform health checks or procedures such as pap smears without compromising patient privacy. Physical capacity is so strained that four nurses use one clinical room and Winnunga is unable to expand on-site specialist medical services due to lack of space. **A priority for 2013-14 is opening a satellite service on the north side of ACT.**

Winnunga summary

Winnunga is a large comprehensive primary health care service provider that caters for more than half of the region's Aboriginal and Torres Strait Islander population and conducts nearly 90% of Aboriginal health checks in the ACT. It deals effectively with complex health needs in a culturally safe and trusted environment (Wong et. al. 2011; Flegg et. al. 2010). Severe physical capacity constraints hamper service delivery and limit medical specialist services in particular. There is a case for a satellite ACCHS in north Canberra, based on rapid Aboriginal population growth and health needs.

Sources: Winnunga *PHA (Practice Health Atlas) General Practice Decision Support Tool for Aboriginal and Torres Strait Islander Peoples* February 2014; *Winnunga Annual Report 2012-13*; ACT 2013. *Closing the Gap Report 2013.* ACT Government http://www.dhcs.act.gov.au/ data/assets/pdf file/0005/471614/ACT-Closing-the-Gap-Report.pdf; Cox, L. 2013. Canberra's Indigenous Unemployment rate Falls. *Canberra Times*. 12 July; Wong, R. et. al. 2011. Positive Impact of a Long-running Urban Aboriginal Medical Service Midwifery Program. *Australian and New Zealand Journal of Obstetrics and Gynaecology 2011.* Volume 51, Issue 6:, 518–522; Flegg, K. et. al. 2010. Health Service Attendance Patterns in an Urban Aboriginal Health Service. *Medical Journal of Australia.* Vol. 193 (3): 146-148.

Rumbalara Medical Centre and Rumbalara Aboriginal Co-operative

ARIA 2
Inner regional - accessible some restrictions to accessibility of some goods and services and opportunities for social interaction

Shepparton/Mooroopna VICTORIA

Population

The Aboriginal population of 2,082 in Greater Shepparton is the largest Aboriginal community in Victoria outside metropolitan Melbourne, accounts for 3.5% of the area's population and is growing rapidly (2011 census). Anecdotal evidence suggests the population could be as high as 6,000 people.

Socio-economic profile

Shepparton is the most socio-economically disadvantaged region in Victoria and among the most disadvantaged in Australia. Year 12 completion rates of 19% are low compared with 36% for non-Aboriginal people and 25% for the Australian Aboriginal population. Non-school qualifications are low at 17%, compared with 23% for local non-Aboriginal people. Aboriginal unemployment rates of 21% are nearly four times those of non-Aboriginal people and labour force participation rates are low (49%; census 2011). Aboriginal home ownership rates are low and waiting lists for public housing long. Homelessness is a big issue in the region, particularly for Aboriginal people. The Aboriginal housing waiting list is 2-4 years and state housing list about 15 years for priority clients.

Rumbalara services

Rumbalara is a large primary health care service open on weekdays, with both a medical and dental clinic and outreach services. Medical Clinic services include management of chronic diseases, antenatal, maternal and infant health care, a strong SEWB team including Link Up, Bringing Them Home, trauma counseling, traditional healing and outreach services, drug, alcohol and rehabilitation assessments and programs, seven different allied health services, health promotion programs and group and community health promotion activities.

Both medical and dental clinics ensure access to primary health care by addressing cost and transport barriers. Both services bulk-bill. Gym passes are given to over 100 clients wanting and needing a formal exercise program, which costs about $15,000 a year. Over 7,000 transport services were provided in 2012-13, 102 of these to specialist services in Melbourne, a 400km round trip.

The Clinics are part of the Rumbalara Aboriginal Co-operative, which provides a range of health-related service and support programs. These include a breakfast program, family services, a men's group and women's group, Elders lunches, the Rumbalara aged care facility, rental housing and home ownership programs and homelessness assistance. The Co-operative responds to individual and community issues and advocates on their behalf when needed. The Co-operative has strong links with the justice system and mentors and supports offenders and families, liaises with the Koori Court in Shepparton and operates a well-used Night Patrol that provided 700 trips in 2012-13 (84% for young people). The Cooperative also has strong links with the *Academy of Sport Health and Education* (ASHE), an Aboriginal TAFE academy in Shepparton that has good outcomes in education/training.

Clients (2012-2013)

The Medical Clinic has 3,446 annual regular clients and 6,338 additional non-regular clients (one visit in past two years). The Dental Clinic has 1,359 clients annually. The total number at both Clinics is 4,825 regular clients. 88% (4,236) of regular clients are Aboriginal. The Clinic serves virtually all

of the local Aboriginal population as well as communities well outside the area. North-east Victoria and southern New South Wales are not well-served by ACCHS. Many clients travel up to two hours, some over 100km and a few more than five hours from southern New South Wales to access Rumbalara. ***There are alternative mainstream primary health care services available but the community preference is extremely strong for the Rumbalara ACCHS and negligible for mainstream services. These are not viewed as culturally acceptable.***

There were 18,125 visits to the Medical Clinic with 25,097 episodes of care in 2012-12. The Dental Clinic had 3,341 visits and provided 8,331 episodes of care. The majority of clients are extremely disadvantaged and vulnerable.

Health profile

The community faces a number of health-related issues including school disengagement, increasing use of the lethal drug ice, unemployment and racism. Trauma rates are high and many Elders have childhood recollections of walking off the Cummeragunga mission on the New South Wales side of the Murray River in protest at conditions, and having family members taken away. Rumbalara SEWB team and mental health services are vital to the community.

Staff (2012-13)

98 of 195 Rumbalara Co-operative staff work in the Medical Clinic, 28 in administration and 70 in health. 34 Clinic staff and 78% of all staff are Aboriginal, with a lower proportion in clinical areas. Cultural orientation for non-Aboriginal and Torres Strait Islander staff is provided.

FTE employment

Occupation/function	**ATSI**	**non-ATSI**	**Total**
CEO	1		1
Managers, supervisors	19	6	25
Admin/clerical	28	9	37
AHW	6		6
GP		5	5
Nurse	15	6	21
Dentist		4	4
Dental assistant	4	3	7
Aged care worker	12		12
Personal care worker	17	3	20
Support worker	32	6	38
Other	19		19
Total	153	42	195

A further 1.55 FTE externally funded health visitors work at the Medical Clinic, including medical specialists, nurses, midwives and allied health professionals.

Partnerships

Rumbalara values partnerships with regional health and other organisations including the Goulburn Valley Primary Care Partnership and Goulburn Valley hospital.

Economic and social value

Education/training: Staff all have at least baseline tertiary Certificate 111 level qualifications. Several staff are continuing education and study, including in nursing and aged care. Rumbalara

offers local work experience placements and is a site for medical, nursing and allied health student training.

Employment and wages/salaries: Rumbalara Aboriginal Co-operative provides employment for 195 people, including 98 in health. ***153 employees are Aboriginal. This accounts for 31% of all Aboriginal employment in the Shepparton area. Wages/salaries in the Clinic are $4.9 million.***

Revenue: The Medical Clinic budget is about $5 million annually. ***It receives about $4 million grants annually of which about 20% are from the State Government.*** Overall Co-operative annual revenue is about $9.1 million.

Capacity constraints

• ***Perennial funding shortages, more than 90 funding agreements and compliance requirements, only 16% of which are recurrent grants. Onerous reporting requirements are a drain on staff.***
• ***Specific service gaps*** lacking funding are youth services, and alcohol, tobacco and other drugs treatment. Rehabilitation services are negligible in the area with clients waiting up to two months for a bed to become available.
• Rumbalara wants to take on more local trainees in health but is constrained by lack of staff supervision time and funding.
• ***Workforce issues*** are perennial, including lack of nurses and attracting and retaining Aboriginal staff. ***Overall staffing levels are strained by high service demands***, with limited replacement staff for staff on sick leave and training. Retention is an issue for all staff, particularly Aboriginal staff who have strong cultural skills and relevant qualifications but lower wages than mainstream service staff.

Rumbalara summary

Rumbalara is a vital community hub. It provides a broad range of health-related services that extend well beyond individual clinical health care. Client care workloads are heavy, with additional strains on administrative staff from demanding reporting requirements to multiple funders. Rumbalara's contribution to regional Aboriginal employment and economic independence is substantial.

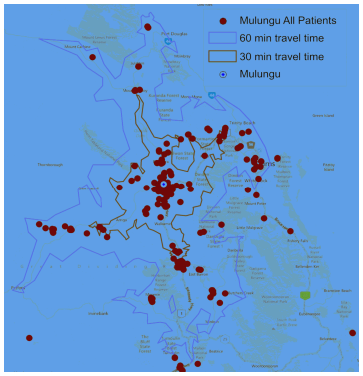
Sources: Rumbalara report to NACCHO 2014; Rumbalara OSR report to Department of Health 2012-13; Rumbalara Aboriginal Co-operative Annual Report 2012-13; ABS census 2011.

Mulungu Aboriginal Corporation Medical Centre

Mareeba, QUEENSLAND

North Queensland

ARIA 3
Outer regional
Moderately Accessible—
significantly restricted accessibility of goods & services & opportunities for social interaction



All patients mapped with 30 & 60 minute travel time

Catchment area

The Shire of Mareeba (LGA) is a rural area of 53,610.8 square kilometres located at the base of Cape York Peninsula in far north Queensland, about 60km inland from the city of Cairns.

Population and socio-economic profile

Aboriginal people in Mareeba Shire represent about 13% (1,349 in 2011) of the population of about 10,583 people (2011 census). The area is relatively disadvantaged in socio-economic terms. Three-quarters of Mulungu Centre's clients are on a pension.

Compared with the non-Aboriginal population in the area, Aboriginal unemployment rates are high (32%, compared with 5% for the total local population) and labour force participation rates low (41%, compared with 60%). Average education levels are low. 19% have completed Year 12 (compared with 37%). 18% have non-school qualifications, compared with 34% of the local population and 25% for Aboriginal Australians on average (2011 census).

Mulungu Aboriginal Corporation Medical Centre services

Mulungu is a large service provider, open on weekdays with home visits available. Mulungu's primary health care approach is holistic, strongly community-focused and responsive to local needs. These include disengagement of young people from school and risk-taking behaviours.

Mulungu has an inter-disciplinary team approach, including GPs, a practice nurse, AHWs, a wellbeing team for health checks and chronic disease care, a Numoo Bubi team (Mums and bubs) for child and antenatal health, and a SEWB team including a *Bringing them Home* counsellor. Mulungu also provides outreach medical care with GPs and AHWs to a local correctional facility two days a week, and to a nearby residential alcohol rehabilitation facility one day a week.

Cost and transport barriers are directly addressed. Mulungu bulk-bills. It provides transport for patients to the Centre, and further afield for specialist appointments including a regular service for dialysis three days a week in Atherton. Mulungu provided 4,857 transport services in 2012-13, including 1,810 external trips.

Service gaps include "a lack of health promotion campaigns specific for the local community: *"A whole of systems approach for promoting wellness and preventing illness is required" (Manager).*

Mulungu clients

Nearly 90% (1,847 people) of the Centre's annual 2,069 clients are Aboriginal, and nearly all local Aboriginal people access Mulungu, as well as communities outside Mareeba. 76% of Aboriginal clients are on a pension. Over 90% visited the Centre over the last twelve months. Many travel considerable distance to access the Centre, some up to one and a half hours by car. Several mainstream GP clinics are bypassed on the way. These measures indicate the community's preference for ACCHS.

Health profile

Over 60% of Aboriginal clients have chronic diseases and multiple morbidities. Mental health conditions are 2.5 times higher than the national benchmark, diabetes 4.7 times and renal impairments nearly 17 times higher.

Staff 72% of 41.8 FTE staff are Aboriginal.

Mulungu staff FTE June 2013	ATSI	Non-ATSI	Total
CEO	1		1
Manager	1		1
Admin/clerical	5		5
Driver	3		3
AHW	6		6
GP		5.4	5.4
Nurse		1	1
Allied health professional (4 areas)		2.9	2.9
SEWB counsellor	2		2
Health promote/prevention	1		1
Program staff (PACE, CFC, MYA)	11	2.5	13.5
TOTAL	**30**	**11.8**	**41.8**

Note: medical specialists are not included.

Effective partnerships enable comprehensive primary health care

• Mulungu enables affordable dentistry, through partnership with a local dentist and copayment (with Medicare) of set fees.

• Mulungu is one of eighty agencies represented in the "Collaboration for Indigenous Outcomes in Mareeba" group that meets quarterly to ensure accountability and link initiatives in education, employment, health and justice systems to assist Aboriginal people in the local area.

• Mulungu regards education as critical to improving community health. It operates a federally government-funded PACE (Parents and Community Engagement) team and a state-funded CFC (Child and Family Centre). These link health with education and employment. Mulungu auspices a

community men's group, and recently had a *Mareeba Young and Awesome (MYA) program* for children who were disengaged from schools and in the justice system.

Economic and social value

- *Community functioning:* "*Mulungu prides itself on tailoring service delivery to the needs of the community*" (Mulungu management). Community engagement is strong through various means including Mulungu providing $43,000 in education or sporting vouchers to local families as incentives for keeping their family healthy.

- *Employment:* all Aboriginal and Torres Strait Islander employees come from the local community. Aboriginal employment at Mulungu accounts for more than 12% of all Aboriginal employment in the area.

- *Wages/salaries:* Combined wages, salaries and employee payments are $2.6 million (2012-13).

- *Revenue:* $5.62 million annually — including grants from twelve separate mainly government sources (largest is DoHA $3.4m).

- *Capital:* property, plant, equipment $5.5 million, land/buildings $4.2 million. Total $9.7 million.

Mulungu summary

Mulungu is a large ACCHS that caters for virtually the entire Aboriginal population in the area and contributes significantly to regional Aboriginal employment. The Centre clearly enhances community wellbeing in directly addressing local issues of school disengagement, crime and alcohol and drug use, based on the unique ACCHS model of primary health care: ***"Mulungu is quite different from a private GP or hospital, and looks at issues more from a community development approach" (Manager).***

"Mulungu has a desire to grow local...leaders to assist with the development of the local Indigenous community and community in general. By increasing the skills and knowledge of people from local Indigenous families, those same people are able to take their skills and knowledge back to their families. ***This empowerment approach has far reaching consequences, beyond just those people employed at Mulungu"*** *(Manager).*

Sources: Mulungu report to NACCHO 2014; Mulungu PHA 2013. *Practice Health Atlas General Practice Decision Support Tool for Aboriginal and Torres Strait Islander Peoples.* June; Mulungu Aboriginal Corporation Medical Centre *Annual Financial Report 2012-13.*

Appendix 1

Reports on Government Services (ROGS)
General Performance Indicator Framework

All services are reported/evaluated against a common general performance indicator framework. The main principles are

Equity
Effectiveness
Efficiency
Access
Appropriateness
Quality

Equity
Measures the gap between service delivery outputs or outcomes for special needs groups and the general population. It includes
• *equity of access:* measures how easily the community can obtain a delivered service (output). All Australians are expected to have appropriate access to services.
• *equity of outcomes*: all Australians are expected to achieve appropriate outcomes from service use.

Effectiveness
Reflects how well the outcomes of a service achieve the stated objectives of that service (eg. cultural competence).

Efficiency
Overall economic efficiency requires satisfaction of technical, allocative and dynamic efficiency:
• *technical efficiency* requires that goods and services be produced at the lowest possible cost
• *allocative efficiency* requires the production of the set of goods and services that consumers value most, from a given set of resources
• *dynamic efficiency* means that over time consumers are offered new and better products, and existing products at lower cost.

Access
Access indicators measure how easily the community can obtain a service. There are two main dimensions:
• *undue delay* (timeliness) — for example, waiting times for patients in public hospitals.
• *undue cost* (affordability) — for example, the proportion of income spent on particular services.

Appropriateness
How well services meet client needs (eg. under-servicing). It could include cultural appropriateness.

Quality
Reflects the extent to which a service is suited to its purpose and conforms to specifications.

Source: Reports on Government Services.

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